

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

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SUBPART A: GENERAL PROVISIONS

Section 148.10 Hospital Services

Sections 148.10 through 148.70 contain participation requirements and coverage limitations for hospital services.

(Source: Recodified from 89 Ill. Adm. Code 140.94 at 13 Ill. Reg. 9572, effective May 31, 1989)

Section 148.20 Participation

- a) Payment for hospital inpatient, outpatient and clinic services shall be made only when provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), for covered services, as described in Section 148.50.
- b) Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided October 1, 1992, through March 31, 1994, shall be as follows:
 - 1) **Base Inpatient Payment Rate.** For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1992, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the base inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under the following Sections: 148.130, 148.260, 148.270, and 148.280.
 - 2) **Exemptions.** The provisions of subsection (b)(1) above shall not apply to:
 - A) Hospitals reimbursed under Sections 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with Sections 148.82, 148.160, or 148.170, as applicable.
 - B) Hospitals reclassified as rural hospitals as described in Section 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with Section 148.40(f)(4) and Section 148.260 or 89 Ill. Adm. Code 149.100(c)(1)(A), whichever is applicable.
 - C) The inpatient payment adjustments described in Sections 148.120, 148.150, and 148.290. Reimbursement for such inpatient payment adjustments shall be in accordance with Sections 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient payment rate described in subsection (b)(1) above.

(Source: Amended at 18 Ill. Reg. 3450, effective February 28, 1994)

Section 148.25 Definitions and Applicability

- a) Payment for hospital inpatient, hospital outpatient and hospital clinic services shall be made only to a hospital or a distinct part hospital unit as defined in this Section.
- b) The term "hospital" means:
 - 1) For the purpose of hospital inpatient reimbursement, any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which is located in the State and is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act or any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located. In addition, unless specifically indicated otherwise, for the purpose of inpatient reimbursement, the term "hospital" shall also include:
 - A) County-owned hospitals, meaning all county-owned hospitals that are located in an Illinois county with a population of over three million.
 - B) A hospital organized under the University of Illinois Hospital Act.
 - C) A hospital unit that is adjacent to or on the premises of the hospital and licensed under the Hospital Licensing Act or the University of Illinois Hospital Act.
 - 2) For the purpose of hospital outpatient reimbursement, the term "hospital" shall, in addition to the definition described in subsection (b)(1) of this Section, include an encounter rate hospital. An encounter rate hospital is defined as:
 - A) An Illinois county-owned hospital located in a county with a population exceeding three million; or
 - B) A hospital organized under the University of Illinois Hospital Act; or
 - C) A county-operated outpatient facility located in a county with a population exceeding three million that is also located in the State of Illinois.
 - 3) For the purpose of non hospital-based clinic reimbursement, the term "hospital" shall mean:
 - A) A county-operated outpatient facility, as described in subsection (b)(2)(D) of this Section; or
 - B) A Certified Hospital Organized Satellite Clinic, as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and subsection (b)(5)(B) of this Section.
 - 4) For the purpose of hospital-based clinic reimbursement, the term "hospital" shall mean a hospital-based clinic meeting the provisions of 89 Ill. Adm. Code 140.461(a) and Section 148.40(d).

- 5) For the purpose of Maternal and Child Health reimbursement, as described in 89 Ill. Adm. Code 140.464 and Section 148.140(d)(6), the term "Maternal and Child Health Managed Care Clinic" shall mean a clinic meeting the requirements of 89 Ill. Adm. Code 140.461(f). The following four categories of Maternal and Child Health Managed Care Clinics are recognized under the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140, Subpart G:
 - A) Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A);
 - B) Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B);
 - C) Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C); and
 - D) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D).
- 6) For the purpose of disproportionate share hospital adjustments, the term "hospital" shall, in addition to the definition in subsection (b)(1) of this Section, mean the facilities operated by the Department of Human Services, including facilities that are accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO).
- c) For the purpose of hospital inpatient reimbursement, the term "distinct part hospital unit" means a hospital, as defined in subsection (b)(1) of this Section, that meets the following qualification(s):
 - 1) Distinct Part Psychiatric Units. A distinct part psychiatric unit is a hospital, with a functional psychiatric unit, that is enrolled with the Department to provide inpatient psychiatric services (category of service 21).
 - 2) Distinct Part Rehabilitation Units. A distinct part rehabilitation unit is a hospital, with a functional rehabilitation unit, that is enrolled with the Department to provide inpatient rehabilitation services (category of service 22).
- d) A major teaching hospital is defined as a hospital having four or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation. Except, in the case of a hospital devoted exclusively to physical rehabilitation, as defined in 89 Ill. Adm. Code 149.50(c)(2), or in the case of a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), only one certified program is required to be so classified.
- e) Except as provided in subsection (d) of this Section, a teaching hospital is defined as a hospital having at least one, but no more than three, graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of

Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.

- f) A non-teaching hospital is defined as:
 - 1) A hospital that reports teaching costs on the Medicare or Medicaid cost reports but has no graduate medical education programs; or
 - 2) A hospital that reports no teaching costs on the Medicare or Medicaid cost reports and that has no graduate medical education programs.
- g) Definitions. Unless specifically stated otherwise, the definitions of terms used in Sections 148.130, 148.260, 148.270, and 148.280, and in 89 Ill. Adm. Code 149 are as follows:
 - 1) "Base period" means the two most recent cost report years for which audited cost reports are available for at least 90 percent of cost reporting hospitals.
 - 2) "Rate period" means:
 - A) For admissions, or if applicable, dates of service, on or after October 1, 1992, and on or before March 31, 1994, the 18 month period beginning on October 1, 1992, and ending on March 31, 1994.
 - B) Beginning with admissions, or if applicable, dates of service, on or after April 1, 1994, the period beginning 90 days after the effective date of DRG PPS rates under the federal Medicare Program and ending 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.
 - 3) "Rural hospital" means a hospital that is:
 - A) Located:
 - i) Outside a metropolitan statistical area; or
 - ii) Located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health.
 - B) The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993).
 - 4) "Urban hospital" means a hospital that is located in a metropolitan statistical area that does not meet the criteria described in subsection (g)(3) of this Section.

(Source: Amended at 26 Ill. Reg. 12322, effective July 26, 2002)

Section 148.30 General Requirements

- a) For the purpose of hospital inpatient, outpatient and hospital-based clinic reimbursement, the following requirements must be met by a hospital to qualify for enrollment in the Illinois Medical Assistance Program:
 - 1) The hospital must be certified for participation in the Medicare Program (Title XVIII) unless the provisions of subsection (a)(2) of this Section apply.
 - 2) If not eligible for or subject to Medicare certification, the hospital must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).
 - 3) The hospital must agree to accept the Department's basis for reimbursement.
- b) Hospitals shall be required to file Medicaid and Medicare cost reports with the Office of Health Finance, Illinois Department of Public Aid, in accordance with Section 148.210, and shall have reimbursable hospital inpatient, outpatient and hospital-based clinic rates approved by the Department.

(Source: Amended at 28 Ill. Reg. 8072, effective June 1, 2004)

Section 148.40 Special Requirements

a) Inpatient Psychiatric Services

- 1) Payment for inpatient hospital psychiatric services shall be made only to:
 - A) A hospital that is a general hospital, as defined in Section 148.25(b), with a functional unit, as defined in Section 148.25(c)(1), that specializes in, and is enrolled with the Department to provide, psychiatric services; or
 - B) A hospital, as defined in Section 148.25(b), that holds a valid license as, and is enrolled with the Department as, a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50(c)(1).
- 2) Inpatient psychiatric services are those services provided to patients who are in need of short-term acute inpatient hospitalization for active treatment of an emotional or mental disorder.
- 3) Inpatient psychiatric services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.
- 4) Federal Medicaid regulations preclude payment for patients over 20 or under 65 years of age in any Institution for Mental Diseases (IMD). Therefore, psychiatric hospitals may not receive reimbursement for services provided to patients over the age of 20 and under the age of 65. In the case of a patient receiving psychiatric services immediately preceding his/her 21st birthday, reimbursement for psychiatric services shall be provided until the earliest of the following:
 - A) The date the patient no longer requires the services; or
 - B) The date the patient reaches 22 years of age.
- 5) A psychiatric hospital must be accredited by the Joint Commission on the Accreditation of Health Care Organizations to provide services to program participants under 21 years of age or be Medicare certified to provide services to program participants 65 years of age and older. Distinct part psychiatric units and psychiatric hospitals located in the State of Illinois, or within a 100 mile radius of the State of Illinois, must execute an interagency agreement with a Department of Human Services (DHS) operated mental health center (State-operated facility) for coordination of services including, but not limited to, crisis screening and discharge

planning to ensure linkage to aftercare services with private practitioners or community mental health services, as described in subsection (a)(6) of this Section.

- 6) **Coordination of Care –Purpose.** In accordance with subsection (a)(5) of this Section, distinct part psychiatric units and psychiatric hospitals located in the State of Illinois, or within a 100 mile radius of the State of Illinois, must execute a Coordination of Care Agreement in order to participate as a provider of inpatient psychiatric services. The Coordination of Care Agreement shall set forth an agreement between the DHS operated mental health center (State-operated facility) and the hospital for the coordination of services, including but not limited to crisis screening and discharge planning to ensure efficient use of inpatient care. The agreement shall also set forth the manner in which linkage to aftercare services with community mental health agencies or private practitioners shall be carried out.
- 7) **Coordination of Care – General Provisions.** The general provisions of the Coordination of Care Agreement described in subsection (a)(6) of this Section are as follows:
 - A) The hospital shall agree, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations and shall maintain accreditation by JCAHO;
 - B) The provider shall comply with Title VI of the Civil Rights Act of 1964 and the Rehabilitation Act of 1973 and regulations promulgated thereunder which prohibit discrimination on the grounds of sex, race, color, national origin or handicap;
 - C) The provider shall comply with the following applicable federal, State and local statutes pertaining to equal employment opportunity, affirmative action, and other related requirements: 42 USCA 2000e, 29 USCA 203 et seq. and 775 ILCS 25;
 - D) The Coordination of Care Agreement shall remain in effect until amended by mutual consent or cancelled in writing by either party having given 30 days prior notification.
- 8) **Coordination of Care – Special Requirements.** The hospital shall:
 - A) Provide on its premises, the facilities, staff, and programs for the diagnosis, admission, and treatment of persons who may require

inpatient care and/or assessment of mental status, mental illness, emotional disability, and other psychiatric problems;

- B) Notify the community mental health agency that serves the geographic area from which the recipient originated to allow the agency to prescreen the case prior to referring the individual to the designated State-operated facility. The community mental health agency's resources and other appropriate community alternatives shall be considered prior to making a referral to the State-operated facility for admission;
 - C) Complete any forms necessary and consistent with the Mental Health and Developmental Disabilities Code in the event of a referral for involuntary or judicial admission;
 - D) Notify the community mental health agency or private practitioner of the date and time of discharge and invite their participation in the discharge planning process;
 - E) Refer to the State-operated facility only those individuals for whom less restrictive alternatives are documented not to be appropriate at the time based on a clinical determination by the community mental health agency, a private practitioner (if applicable), or the hospital; and
 - F) Notify the State-operated facility prior to planned transfer of an individual and transfer the individual at such time as to assure arrival of the person prior to 11 a.m. Monday through Friday. In unusual situations, transfers may be made at other times after prior discussion between the hospital and the State-operated facility. The individual will only be transported to the State-operated facility when, based on a clinical determination, he/she is medically stable as determined by the transferring physician. A copy of the transfer summary from the hospital must accompany the recipient at the time of admission to the State-operated facility.
- 9) Coordination of Care – Special Requirements of the State-Operated Facility. The State-operated facility shall:
- A) Admit individuals who have been screened as defined in the Coordination of Care Agreement and are appropriate for admission consistent with the provisions of the Mental Health and Developmental Disabilities Code.

- B) Evaluate individuals for whom the hospital has executed a Petition and Certificate for involuntary/judicial admission consistent with the Mental Health and Developmental Disabilities Code.
 - C) Consider for admission voluntary individuals for whom less restrictive alternatives are documented not to be appropriate at the time, based on a clinical determination by the community mental health agency, private practitioner (if applicable), the hospital, or the State-operated facility.
 - 10) Coordination of Care – Special Requirements for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program. For patients under 21 years of age, all inpatient admissions must be authorized through the SASS Program. The hospital shall:
 - A) Prior to admission, contact the Crisis and Referral Entry Service (CARES), the Department's Statewide centralized intake and referral point for a mental health screening and assessment of the patient, pursuant to 59 Ill. Adm. Code 131.40;
 - B) For admissions authorized through a SASS screening, involve the SASS provider in the patient's treatment plan during the inpatient stay and in the development of a discharge plan in order to facilitate linkage to appropriate aftercare resources.
 - 11) A participating hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service only on an emergency basis for a maximum period of 72 hours or in cases in which the psychiatric services are secondary to the services for which the period of hospitalization is approved.
- b) Inpatient Rehabilitation Services
- 1) Payment for inpatient rehabilitation services shall be made only to a general hospital, as defined in Section 148.25(b), with a functional unit of the hospital, as defined in Section 148.25(c)(2), which specializes in, and is enrolled with the Department to provide, physical rehabilitation services or a hospital, as defined in 89 Ill. Adm. Code 149.50(c)(2), which holds a valid license as, and is enrolled with the Department as, a physical rehabilitation hospital.
 - 2) The primary reason for hospitalization is to provide a structured program of comprehensive rehabilitation services, furnished by specialists, to the

patient with a major handicap for the purpose of habilitating or restoring the person to a realistic maximum level of functioning.

- 3) Inpatient rehabilitation services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.
- 4) For payment to be made, a rehabilitation facility, which includes a distinct part unit as described in Section 148.25(c)(2), must be certified by the Health Care Financing Administration for participation under the Medicare Program (Title XVIII) and must be licensed and/or certified by the Department of Public Health (DPH) to provide comprehensive physical rehabilitation services. Out-of-state hospitals that specialize in physical rehabilitation services must be licensed or certified to provide comprehensive physical rehabilitation services by the authorized licensing agency in the state in which the hospital is located.
- 5) A rehabilitation facility must meet the following criteria:
 - A) Have a full-time (at least 35 hours per week) director of rehabilitation; a participating general hospital with a functional rehabilitation unit must have a part-time (at least 20 hours per week) director of rehabilitation;
 - B) Have an organized medical staff;
 - C) Have available consultants qualified to perform services in appropriate specialties;
 - D) Have adequate space and equipment to provide comprehensive diagnostic and treatment services;
 - E) Maintain records of diagnosis, treatment progress (notations must be made at regular intervals) and functional results; and
 - F) Submit reports as required by the Department of Public Aid (DPA).
- 6) A rehabilitation facility must provide, or have a contractual arrangement with an appropriate entity or agency to provide, the following minimal services:
 - A) Full-time nursing services under the supervision of a registered nurse formally trained in rehabilitation nursing;

- B) Full-time physical therapy and occupational therapy services; and
 - C) Social casework services as an integral part of the rehabilitation program.
- 7) A rehabilitation facility must have available the following minimal services:
- A) Psychological evaluation services;
 - B) Prosthetic and orthotic services;
 - C) Vocational counseling;
 - D) Speech therapy;
 - E) Clinical laboratory and x-ray services; and
 - F) Pharmacy services.
- 8) The director of rehabilitation must meet the following criteria:
- A) Provide services to the hospital and its patients as specified in subsection (b)(5) of this Section;
 - B) Be a doctor of medicine or osteopathy;
 - C) Be licensed under State law to practice medicine or surgery; and
 - D) Must have, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.
- 9) Personnel of the rehabilitation facility must meet the following minimum standards:
- A) Physicians shall have unlimited licenses to practice medicine and surgery in the state in which they practice. Consultants shall be Board Qualified or Board Certified in their specialty.
 - B) Physical therapists shall be licensed by the Illinois Department of Professional Regulation.

- C) Occupational therapists shall be licensed by the Illinois Department of Professional Regulation.
 - D) Registered nurses and licensed practical nurses shall be currently licensed by the Illinois Department of Professional Regulation or comparable licensing agency in the State in which the facility is located.
 - E) Social workers shall have completed two years of graduate training leading to a Master's Degree in social work from an accredited graduate school of social work.
 - F) Psychologists shall have a Master's Degree in clinical psychology.
 - G) Vocational counselors shall have a Master's Degree in Rehabilitation Counseling, Psychology or Guidance from a school accredited by the North Central Association or its equivalent.
 - H) An orthotist or prosthetist, certified by the American Board of Certification in Orthotics and Prosthetics, shall fabricate or supervise the fabrication of all limbs and braces.
- c) End-Stage Renal Disease Treatment (ESRDT) Services. The Department provides payment to hospitals, as defined in Section 148.25(b), for ESRDT services only when the hospital is Medicare certified for ESRDT and services are provided as follows:
- 1) Inpatient hospital care is provided for the evaluation and treatment of acute renal disease;
 - 2) Outpatient chronic renal dialysis treatments are provided in the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, or a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subpart U (1994); or
 - 3) Home dialysis treatments are provided through the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, in a patient's home, or through a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subpart U (1994).

- d) Hospital-Based Organized Clinic Services. Hospital-based clinics, as described in Section 148.25(b)(4), must meet the requirements of 89 Ill. Adm. Code 140.461(a). The following two categories of hospital-based organized clinic services are recognized in the Medical Assistance Program:
- 1) Psychiatric Clinic Services
 - A) Psychiatric Clinic Services (Type A). Type A psychiatric clinic services are clinic service packages consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling, provided in the hospital clinic setting.
 - B) Psychiatric Clinic Services (Type B). Type B psychiatric clinic services are active treatment programs in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four hours per day at a minimum of three half days of active treatment per week. The duration of an individual patient's participation in this treatment program is limited to six months in any 12 month period.
 - C) Coverage. Psychiatric clinic services are covered for all Medicaid-eligible individuals. The services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.
 - D) Approval. The Department of Human Services and DPA are responsible for approval and enrollment of community hospitals providing psychiatric clinic services. In order to participate as a provider of psychiatric clinic services, a hospital must have previously been enrolled with the Department for the provision of inpatient psychiatric services on or after June 1, 2002 or must be currently enrolled for the provision of inpatient psychiatric services and execute a Psychiatric Clinic Services Type A and B Enrollment Assurance with DHS and DPA, which assures that the hospital is enrolled for the provision of inpatient psychiatric services and meets the following requisites:
 - i) The hospital must be accredited by, and be in good standing with, the Joint Commission on Accreditation of Health Care Organizations (JCAHO);

- ii) The hospital must have executed a Coordination of Care Agreement between the hospital and the designated DHS State-operated facility serving the mentally ill in the appropriate geographic area;
 - iii) The clinical staff of the psychiatric clinic must collaborate with the mental health service network to provide discharge, linkage and aftercare planning for recipients of outpatient services;
 - iv) The hospital must agree to participate in Local Area Networks in compliance with P.L. 99-660 and P.A. 86-844; and
 - v) The hospital must be enrolled to participate in Medicaid Program (Title XIX) and must meet all conditions and requirements set forth by DPA.
 - E) Duration of Approval. The approval described in subsection (d)(1)(D) of this Section shall be in effect for a period of two years from the date DPA approves the psychiatric clinic's enrollment. The approval may be terminated by DPA or DHS with cause upon 30 days written notice to the hospital. Accordingly, the hospital must submit a 30 day written notification to DPA and DHS when terminating delivery of psychiatric clinic services.
- 2) Physical Rehabilitation Clinic Services
- A) Physical rehabilitation clinic services include the same rehabilitative services provided to inpatients by hospitals enrolled to provide the services described in Section 148.40(b). Clinic services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an outpatient basis through the hospital's specialized clinic.
 - B) Physical rehabilitation clinic services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.
- e) Maternal and Child Health Managed Care Clinics. Maternal and Child Health Managed Care Clinics, as described in 89 Ill. Adm. Code 140.461(f) and Section 148.25(b)(5), must meet the requirements of 89 Ill. Adm. Code 140.461(f).

- f) Transition to the Diagnosis Related Grouping Prospective Payment System (DRG PPS) (see 89 Ill. Adm. Code 149)
- 1) Effective with admissions occurring on or after September 1, 1991, and before October 1, 1992, hospitals shall be reimbursed in accordance with the statutes and administrative rules governing the time period when the services were rendered.
 - 2) Effective with admissions occurring on or after October 1, 1992, hospitals that, on August 31, 1991, had a contract in effect with the Department under the Illinois Health Finance Reform Act [20 ILCS 2215] and that elected, effective September 1, 1991, to be reimbursed at rates stated in such contracts, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care in accordance with subsection (g) of this Section.
 - 3) In the case of a hospital that was determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient services during the rate period described in Section 148.25(g)(2)(A):
 - A) the DRG PPS, as described in 89 Ill. Adm. Code 149, or
 - B) the rate calculated under Section 148.260.
 - 4) In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in Section 148.25(g)(3), on July 14, 1993, those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A):
 - A) the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(c)(1), or
 - B) the rate calculated under Section 148.260 that would have been in effect for the rate period described in Section 148.25(g)(2)(A) if

the hospital had been designated as a sole community hospital on October 1, 1992.

- 5) For the rate periods described in Section 148.25(g)(2)(B), hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided during such rate periods described in Section 148.25(g)(2)(B):

A) the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(c)(1), or

B) the rate calculated under Section 148.260.

g) Annual Irrevocable Election

- 1) Hospitals described in subsections (f)(2) and (f)(3) of this Section may elect to be reimbursed under the special arrangements described in subsections (f)(2) and (f)(3) at the beginning of each rate period.
- 2) Hospitals described in subsection (f)(4) of this Section may elect to be reimbursed under the special arrangements described in subsection (f)(4) effective with admissions, or, if applicable, with inpatient services provided, on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A).
- 3) Hospitals described in subsection (f)(5) of this Section may elect to be reimbursed under the special arrangements described in subsection (f)(5) at the beginning of each rate period described in Section 148.25(g)(2)(B).
- 4) Once a sole community hospital elects to be reimbursed under the DRG PPS, it may not later in that rate period elect to be classified as exempt. Once a sole community hospital elects to be reimbursed as exempt, it may not later in that rate period elect to be reimbursed under the DRG PPS.
- 5) Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care. Once such election has been made, the hospital may not later in that rate period elect to be reimbursed under any other methodology.
- 6) Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act and have elected to be

reimbursed under the DRG PPS may not later elect to be reimbursed at rates stated in such contracts.

- h) Notification of Reimbursement Methodology
 - 1) Hospitals shall receive notification from the Department with respect to the reimbursement methodologies that shall be in effect for admissions occurring during the rate period.
 - 2) Hospitals described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) of this Section shall receive notification of their reimbursement options accompanied by a Choice of Reimbursement form. Each hospital described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) shall have 30 days after the date of such notification to file, with the Department, the reimbursement method of choice for the rate period. In the event the Department has not received the hospital's Choice of Reimbursement form within 30 days after the date of notification, as described in this Section, the hospital will automatically be reimbursed for the rate period under the reimbursement methodology that would have been in effect without benefit of the election described in subsection (g) of this Section.
- i) Zero Balance Bills. The Department requires a hospital to submit a bill for any inpatient service provided to an Illinois Medicaid eligible person, including newborns, regardless of payor. A "zero balance bill" is one on which the total "prior payments" are equal to or exceed the Department's liability on the claim. The Department requires that zero balance bills be submitted subsequent to discharge in the same manner as are other bills so that information can be available for the maintenance of accurate patient profiles and diagnosis-related grouping (DRG) data, and information needed for calculation of disproportionate share and other rates. The provisions of this subsection apply to all hospitals regardless of the reimbursement methodology under which they are reimbursed.

(Source: Amended at 29 Ill. Reg. 5514, effective April 1, 2005)

Section 148.50 Covered Hospital Services

- a) The Department shall pay hospitals for the essential provision of inpatient, outpatient, and clinic diagnostic and treatment services not otherwise excluded or limited which are provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), and which are provided in compliance with hospital licensing standards. Payment may be made for the following types of care subject to the special requirements described in Section 148.40:
 - 1) General/specialty services;
 - 2) Psychiatric services;
 - 3) Rehabilitation services; and
 - 4) End-Stage Renal Disease Treatment (ESRDT) services.
- b) Certain programs are administered as hospital covered services with certain restrictions. These programs include hospital residing long term care services, subacute alcoholism and substance abuse treatment services, and the transplant program.
- c) Hospital Residing Long Term Care Services
 - 1) Long term care services are not considered by the Department to be hospital services unless the hospital is enrolled with the Department specifically to provide hospital residing long term care services as a hospital-based long term care facility. Hospital residing long term care is care provided by hospitals to non-acute patients requiring chronic, skilled nursing care when a skilled nursing facility bed is not available, or non-acute care provided by hospitals that is not routinely performed within a skilled setting, such as ventilator care, when appropriate placements are not available to discharge the patient. Hospitals may not utilize the following beds or facilities for hospital services unless the hospital is enrolled with the Department to provide hospital residing long term care:
 - A) A special unit or specified beds which are certified for skilled nursing facility services under the Medicare Program; or
 - B) A special unit or separate facility administratively associated with the hospital and licensed as a long term care facility.
 - 2) There are three categories of service for hospital residing long term care. These categories are as follows:
 - A) Skilled Care – Hospital Residing (category of service 37)
Reimbursement is available for hospitals providing hospital residing long term care when the patients' needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed. Reimbursement for this type of care is at the average statewide rate for skilled nursing care. For a hospital to be eligible for such reimbursement, the following criteria must be met:

- i) The hospital must document its attempt to place the patient in at least five appropriate facilities.
 - ii) Documentation (form DPA 3127) must be attached to the appropriate claim form and submitted to the Department.
 - iii) Reimbursement is limited to services provided after the minimum number of contacts have been made.
Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement will be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.
- B) Exceptional Care – Hospital Residing (category of service 38)
Reimbursement is available for hospitals providing hospital residing long term care when the level of care is not routinely performed within a skilled setting, such as ventilator care, and the patient cannot be placed in a skilled nursing facility because the level of care is not available. Exceptional care is defined by the Department as the level of care required by persons who are medically stable and ready for discharge from a hospital but who require a multi-disciplinary level of care for physician, nurse, and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be a medical necessity. This includes, but is not limited to, persons with acquired immune deficiency syndrome (AIDS) or a related condition, head injured persons, and ventilator dependent persons. Reimbursement for this type of care is at the average statewide rate for exceptional care. For a hospital to be eligible for such reimbursement, the following criteria must be met:
- i) The hospital must document its attempt to place the patient in at least five appropriate facilities.
 - ii) Documentation (form DPA 3127) must be attached to the appropriate claim form and submitted to the Department.
 - iii) Reimbursement is limited to services provided after the minimum number of contacts have been made.
Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement will be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.
- C) DD/MI Non-Acute Care – Hospital Residing (category of service 39)

Reimbursement is available for hospitals providing hospital residing long term care when the pre-admission screening agent has not completed the assessment, planning or discharge process. Reimbursement for this type of care is at the average statewide DD/MI rate. For a hospital to be eligible for such reimbursement, the following criteria must be met:

- i) The hospital must document that the pre-admission screening agent has not completed the assessment, planning or discharge process.
 - ii) Reimbursement is limited to a maximum of three non-acute level of care days. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary.
- d) Subacute Alcoholism and Substance Abuse Treatment Services
- 1) Subacute alcoholism and other substance abuse treatment is a covered service for clients under Title XIX (Medicaid) and for children 13 to or through 18 years of age in Family and Children Assistance cases in the City of Chicago.
 - 2) Only acute alcoholism and substance abuse treatment services (detoxification) are covered as hospital services. Regulations regarding reimbursement for subacute alcoholism and substance abuse treatment services may be found under Sections 148.340 through 148.390.
- e) Transplant Program
- The Medical Assistance Program provides for payment for organ transplants only when provided by a certified transplantation center as described in Section 148.82. Payment for kidney and cornea transplants does not require enrollment as an approved transplantation center. Payment for kidney and cornea transplants is made in accordance with the appropriate methodology described in Sections 148.160, 148.170, 148.250 through 148.300, or 89 Ill. Adm. Code 149.100 and 149.150. Kidney acquisition costs shall be reimbursed in accordance with 89 Ill. Adm. Code 149.150(c)(5). Payment for bone marrow, heart, liver, pancreas, kidney/pancreas and other types of transplant procedures may be covered and reimbursed in accordance with Section 148.82 provided the hospital is certified by the Department to perform the transplant.

(Source: Amended at 18 Ill. Reg. 3450, effective February 28, 1994)

Section 148.60 Services Not Covered as Hospital Services

Certain services, although included in the Medical Assistance Program and under certain circumstances provided in the hospital setting or by an entity associated with the hospital, are not reimbursed by the Department as hospital services. In addition, certain services currently provided in the hospital outpatient and hospital-based clinic setting are subject to fee-for-service payment methodologies. This means that for these services, hospitals shall be required to conform to the policies and billing procedures in effect for other non-hospital providers of services. Payment for these services shall be based on the same fee schedule that applies to these services when they are provided in the non-hospital setting. Services not covered or reimbursed as hospital services are as follows:

- a) Private Duty Nursing Services. Private duty nursing services for hospitalized program participants are not covered under the Medical Assistance Program. Hospitals are expected to provide all required nursing services.
- b) Sitter Services. Sitter services for hospitalized program participants are not covered under the Medical Assistance Program.
- c) Dental Services. Hospitals may not enroll to provide dental services. When dental services are provided in the outpatient/clinic setting of a hospital, the dentist shall submit charges to the Department according to the provisions of the Dental Program.
- d) Nurse Anesthetist Services. Payment for general anesthesia services not reimbursed under 89 Ill. Adm. Code 140.400 shall be made only to hospitals that qualify for these payments under the Medicare Program (Social Security Act, Title XVIII) and shall be made to such hospitals when provided by a hospital employed nonphysician anesthetist (Certified Registered Nurse Anesthetist or "CRNA").
- e) Pharmacy Services. Policy and reimbursement for pharmacy services are described in 89 Ill. Adm. Code 140.440 through 140.450. A hospital pharmacy may enroll on a fee-for-service basis for services provided to a patient in:
 - 1) A specified bed or special hospital unit which is certified for skilled nursing facility services under the Medicare Program;
 - 2) A special hospital unit or separate facility which is administratively associated with the hospital and is licensed as a long term care facility; or
 - 3) The outpatient/clinic setting when the services provided are not unique to the hospital setting.
- f) Medical Transportation Services. A hospital that owns and operates medical transportation vehicles as a separate entity (for example, a private corporation) must enroll as a medical transportation provider. A hospital that owns and operates medical transportation vehicles that are included on the hospital's cost report as a cost center of the hospital may not submit a separate claim for transportation services provided to persons admitted as inpatients. Policy and reimbursement for medical transportation services is described in 89 Ill. Adm. Code 140.490 through 140.492.

- g) Home Health Services. Home health services are not considered by the Department to be hospital services. A home health agency that is administratively associated with a hospital and that is certified for participation as a home health agency by the Medicare Program may apply for participation for the provision of home health services. Policy and reimbursement for home health services is described in 89 Ill. Adm. Code 140.470 through 140.474.
- h) Subacute Alcoholism and Substance Abuse Treatment Services. Only acute alcoholism and substance abuse treatment services (i.e., detoxification) are covered as hospital services. Regulations regarding reimbursement for subacute alcoholism and substance abuse treatment services may be found under Sections 148.340 through 148.390.
- i) Hospice Services. Hospice is an alternative to traditional Medicaid coverage. The Hospice Program is responsible for all the client's medical needs related to a terminal illness. If a client chooses the Hospice Program, a physician must certify that the client is terminally ill and has a life expectancy of six months or less.

(Source: Amended at 26 Ill. Reg. 12322, effective July 26, 2002)

Section 148.70 Limitation On Hospital Services

- a) Payment for inpatient hospital care in general and specialty hospitals, including psychiatric hospitals, shall be made only when it is recommended by a qualified physician and the care is essential as determined by the appropriate utilization review authority. For hospitals or distinct part units reimbursed on a per diem basis under Sections 148.160 through 148.170 and 148.250 through 148.300, payment shall not exceed the number of days approved for the recipient's care by the appropriate utilization review authority (see Section 148.240). If Medicare benefits are not paid because of non-approval by the utilization review authority, payment shall not be made on behalf of the Department.
- b) For hospitals or distinct part units reimbursed on a per case basis, payment for inpatient hospital services shall be made in accordance with 89 Ill. Adm. Code 149.
- c) For hospitals, or distinct part units reimbursed on a per diem basis, under Sections 148.160 through 148.170 and 148.250 through 148.300, payment for inpatient hospital services shall be made based on calendar days. The day of admission shall be counted. The day of discharge shall not be counted. An admission with discharge on the same day shall be counted as one day. If a recipient is admitted, discharged and re-admitted on the same day, only one day shall be counted.
- d) In obstetrical cases, payment for services to both the mother and the newborn child shall be made at one per diem rate, or one per case rate, whichever is applicable. Only in instances in which the medical condition of the newborn, as certified by the utilization review authority, necessitates care in other than the newborn nursery, shall payment be made in the child's name separately.
- e) Payment for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50(c)(1), shall be made only when such services have been provided in accordance with federal regulations at 42 CFR 441, Subparts C and D.
- f) Payment for transplantation costs (with the exception of kidney and cornea transplants), including organ acquisition costs, shall be made only when provided by an approved transplantation center as described in Section 148.82. Payment for kidney and cornea transplantation costs does not require enrollment as an approved transplantation center and is only provided to hospitals reimbursed on a per case basis in accordance with 89 Ill. Adm. Code 149.

(Source: Amended at 26 Ill. Reg. 13661, effective September 3, 2002)

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.80 Organ Transplants Services Covered Under Medicaid (Repealed)

(Source: Repealed at 17 Ill. Reg. 14643, effective August 30, 1993)

Section 148.82 Organ Transplant Services**a) Introduction**

The Department of Public Aid will cover organ transplants as identified under subsection (b) of this Section that are provided to United States citizens or aliens who are lawfully admitted for permanent residence in the United States under color of law pursuant to 42 USC 1396a(a) and 1396b(v). Such services must be provided by certified organ transplant centers which meet the requirements specified in subsections (c) through (h) of this Section.

b) Covered Services

- 1) Inpatient heart, heart/lung, lung (single or double), liver, pancreas or kidney/pancreas transplantation. Inpatient bone marrow transplants, inpatient and outpatient stem cell transplants.
- 2) Inpatient intestinal (small bowel or liver/small bowel) transplantation for children only (see subsection (d)(1)(H) of this Section).
- 3) Other types of transplant procedures may be covered when a hospital has been certified by the Department as a transplant center eligible to perform such transplants. Centers must complete the certification process established in subsection (c) of this Section and provide the necessary documentation of the number of transplant procedures performed and the survival rates.
- 4) Medically necessary work-up.

c) Certification Process

- 1) In order to be certified to receive reimbursement for transplants performed on Medical Assistance and KidCare patients, the hospital must:
 - A) Request an application from the Bureau of Comprehensive Health Services;
 - B) Submit a completed application to the Department for the type of transplant for which the center is seeking certification;
 - C) Meet certification criteria established in subsection (d) of this Section, based upon review and recommendation of each application by the State Medical Advisory Committee (SMAC); and

- D) Submit a detailed status report on each patient for the type of transplant for which the hospital is seeking certification. Such reports must include the patient's diagnosis, date of transplant, the length of hospitalization, charges, survival rates, patient-specific transplant outcome, and complications (including cause of death, if applicable) for all transplants performed in the time frames required for the type of transplant indicated in subsections (d)(1)(C), (D), (E), (F), (G), (H), (I) or (J) of this Section. To protect the privacy of patients included in this report, names of patients who are not covered under Medical Assistance or KidCare are not required.
 - 2) The Department shall notify the hospital of approval or denial of the hospital as a transplant center for Medical Assistance and KidCare eligible patients.
 - 3) In the event the Department receives a request for prior approval to provide a service from a hospital not formally certified under this Section, the Department may approve the request if it determines that circumstances are such that the health, safety and welfare of the recipient would best be served by receiving the service at that hospital. In making its determination, the Department shall take into account the hospital's, and its medical staff's, ability and qualifications to provide the service, the burden on the recipient's family if a certified hospital is a great distance from their home, and the urgent nature of the transplant.
 - 4) A joint application combining the statistical data for the adult and pediatric programs from two affiliated hospitals that share the same surgeons may be submitted for review by the State Medical Advisory Committee. The hospitals must meet the criteria under subsections (d)(1)(A), (B), (K), (L), (M), (N), (O), (P) and (Q), the applicable criteria under subsections (d)(1)(C), (D) or (J) and (d)(1)(R), subsections (d)(2), (3) and (4), and subsection (e) of this Section for certification and recertification.
- d) Certification Criteria
- 1) Hospitals seeking certification as a transplant center shall submit documentation to verify that:
 - A) The hospital is capable of providing all necessary medical care required by the transplant patient;
 - B) The hospital is affiliated with an academic health center;

- C) The hospital has had the transplant program for inpatient adult heart and liver transplants in operation for at least three years with 12 transplant procedures per year for the past two years and 12 cases in the three year period preceding the most current two year period for adult heart and liver transplants;
- D) The hospital has had the transplant program for inpatient adult heart/lung and lung transplants in operation for at least three years with ten transplant procedures per year for the past two years and ten cases in the three year period preceding the most current two year period for adult heart/lung and lung transplants;
- E) A hospital specializing in inpatient pediatric heart/lung and lung transplants has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three year period preceding the most current two year period;
- F) The hospital has had the transplant program for inpatient adult and pediatric bone marrow transplants in operation for at least two years with 12 transplant procedures per year for the past two years;
- G) The hospital performing outpatient adult and pediatric stem cell transplants must be part of a certified inpatient program and must have been in operation for at least two years with at least 12 outpatient stem cell transplant procedures per year in the past two years;
- H) A hospital specializing in inpatient pediatric heart or liver transplants, or both, has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three year period preceding the most current two year period;
- I) A hospital specializing in inpatient pediatric intestinal (small bowel or liver/small bowel) transplants has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three year period preceding the most current two year period;
- J) A hospital specializing in inpatient kidney/pancreas and/or pancreas transplants has had the transplant program in operation

for at least three years with 25 kidney transplant procedures per year for the past two years and 25 cases in the three year period preceding the most current two year period, and five pancreas transplant procedures per year for the past two years and five in the three year period preceding the most current two year period, or 12 kidney/pancreas transplant procedures per year for the past two years and 12 in the three year period preceding the most current two year period;

- K) The hospital has experts, on staff, in the fields of cardiology, pulmonology, anesthesiology, immunology, infectious disease, nursing, social services, organ procurement, associated surgery and internal medicine to complement the transplant team. In addition, in order to qualify as a transplant center for pediatric patients, the hospital must also have experts in the field of pediatrics;
- L) The hospital has an active cardiovascular medical and surgical program as evidenced by the number of cardiac catheterizations, coronary arteriograms and open heart procedures per year for heart and heart/lung transplant candidates;
- M) The hospital has pathology resources that are available for studying and reporting the pathological responses for transplantation as supported by appropriate documentation;
- N) The hospital complies with applicable State and federal laws and regulations;
- O) The hospital participates in a recognized national donor procurement program for organs or bone marrow provided by unrelated donors, abides by its rules, and provides the Department with the name of the national organization of which it is a member;
- P) The hospital has an interdisciplinary body to determine the suitability of candidates for transplantation as supported by appropriate documentation;
- Q) The hospital has blood bank support necessary to meet the demands of a certified transplant center as supported by appropriate documentation; and
- R) The hospital meets the applicable transplant survival rates as supported by the Kaplan-Meier method or other method accepted by the Department:

- i) A one-year survival rate of 50 percent for inpatient bone marrow and inpatient and outpatient stem cell transplant patients;
 - ii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for heart transplant patients;
 - iii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for liver transplant patients;
 - iv) A one-year survival rate of 90 percent for kidney transplant and a one-year survival rate of 80 percent for pancreas transplant; or a one-year survival rate of 80 percent for kidney/pancreas transplant;
 - v) A one-year survival rate of 65 percent and a two-year survival rate of 60 percent for heart/lung and lung (single or double) transplant patient;
 - vi) A one-year survival rate of 60 percent and a two-year survival rate of 55 percent for intestinal transplants (small bowel or liver/small bowel).
- 2) The commitment of the hospital to support the transplant center must be at all levels as evidenced by such factors as financial resources, allocation of space and the support of the professional staff for the transplant program and its patients. The hospital must submit appropriate documentation to demonstrate that:
 - A) Component teams are integrated into a comprehensive transplant team with clearly defined leadership and responsibility;
 - B) The hospital safeguards the rights and privacy of patients;
 - C) The hospital has adequate patient management plans and protocols to meet the patient and hospital's needs.
- 3) The hospital must identify, in writing, the director of the transplant program and the members of the team as well as their qualifications. Physician team members must be identified as board certified, in preparation for board certification, or pending board certification, and the transplant coordinator's name must be submitted.

- 4) The hospital must provide patient selection criteria including indications and contraindications for the type of transplant procedure for which the facility is seeking certification.
- e) Recertification Process/Criteria
- 1) The Department will conduct an annual review for certification of transplant centers. A certified center must submit documentation established under subsections (c), (d), (f) and (h) of this Section for review by the Department's State Medical Advisory Committee for recertification as a transplant center.
 - 2) Survival rates of previous transplant patients must be documented prior to certification. The center must maintain patient volume in the year of certification based on previous transplant statistics.
 - 3) The Department shall notify the hospital of approval or denial of the recertification of the hospital as a transplant center.
 - 4) If the hospital has previously met the requirements for certification or recertification of its program under subsections (d)(1), (K), (L), (M), (N), (O), (P) and (Q) and (d)(2), (3) and (4) of this Section and the program has experienced no changes under the above subsections, as evidenced in written documentation on the hospital's application, the hospital will not be required to resubmit the same data.
 - 5) If a center has previously met the requirements for certification or recertification of its program under subsections (d)(1) (K), (L), (M), (N), (O), (P), (Q) and (R)(i) through (R)(vi), but has performed fewer than the required number of transplants pursuant to subsections (d)(1)(C), (D), (E), (F), (G), (H), (I) or (J) as appropriate, the Department may recertify the center if it determines that the best interests of the Medical Assistance or KidCare client eligible for transplant services would be served by allowing continued certification of the center. Criteria the Department may consider in making such a determination include, but are not limited to:
 - A) Not recertifying a center would limit the accessibility of available organs.
 - B) Other centers are not accepting new patients or have extensive waiting lists.
 - C) The distance to other eligible centers would jeopardize the client's opportunity to receive a viable organ/tissue transplant.

f) Notification of Transplant

- 1) The hospital must notify the Department prior to performance of the transplant procedure. The notification letter must be from a physician on the transplant team.
- 2) The notification must include the admission diagnosis and pre-transplant diagnosis.
- 3) The Department shall notify the hospital regarding receipt of the notification and provide the appropriate outcome summary forms to the hospital.

g) Reimbursement

- 1) Hospital services rendered for transplant procedures under this Section are exempt from the provisions of Sections 148.250 through 148.330 and 89 Ill. Adm. Code 149 of the Department's administrative rules governing hospital reimbursement. Hospital reimbursement for transplants covered within this Section is an all-inclusive rate for the admission, regardless of the number of days of care associated with that admission, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for a maximum number of days listed below for specific types of transplants:
 - A) 30 consecutive days of post-operative inpatient care for heart, heart/lung, lung (single or double), pancreas, or kidney/pancreas transplant; or
 - B) 40 consecutive days of post-operative inpatient care for liver transplant; or
 - C) 50 consecutive days of post-operative inpatient care for bone marrow transplant (this includes a maximum of seven days prior to the transplant for infusion of chemotherapy), or 50 consecutive days of care for an inpatient or outpatient stem cell transplant; or
 - D) 70 consecutive days of post-operative inpatient care for intestinal (small bowel or liver/small bowel) transplants; or
 - E) For those transplants covered under subsection (b)(2) of this Section, the number of consecutive days of inpatient care specified within the transplant certification process.

- 2) Reimbursement will be approved only when the Department's letter acknowledging the notification of the transplant procedure is attached to the hospital's claim. Reimbursement will not be made until the discharge summary has been submitted to the Department.
 - 3) Applicable disproportionate share payment adjustments shall be made in accordance with Section 148.120(g). Applicable outlier adjustments shall be made in accordance with Section 148.130. Applicable Medicaid High Volume adjustments shall be made in accordance with Section 148.290(d).
 - 4) The rate will not include transportation and physician fees when reimbursed pursuant to 89 Ill. Adm. Code 140.410 through 140.414 and 140.490 through 140.492, respectively.
 - 5) Hospital reimbursement for bone marrow searches is limited to 60 percent of charges up to a maximum of \$25,000. Payment for bone marrow searches will only be made to the certified center requesting reimbursement for the bone marrow transplant.
 - 6) Reimbursement for stem cell acquisition charges which includes the mobilization, chemotherapy, cytokines and apheresis processes must be billed under the appropriate revenue code on the claim submitted for the transplant procedure.
- h) Reporting Requirements of Certified Transplant Center
The following documentation must be submitted within the time limits set forth in this subsection (h).
- 1) Outcome Summary
 - A) The discharge summary for each Medical Assistance and KidCare patient must be received by the Department within 30 days after the patient's discharge.
 - B) For those Medical Assistance and KidCare patients who expire, a summary must be received by the Department within 30 days after the patient's death.
 - 2) Notification of Changes
The center must notify the Department within 30 days after any changes in its program including, but not limited to, certification criteria, patient selection criteria, members of the transplant team and the coordinator.

(Source: Amended at 28 Ill. Reg. 7101, effective May 3, 2004)

Section 148.85 Supplemental Tertiary Care Adjustment Payments

- a) Qualifying Criteria. Supplemental Tertiary Care Adjustment Payments, as described in subsection (b) of this Section, shall be made to all qualifying Illinois hospitals. An Illinois hospital shall qualify for payment if it was deemed eligible for payments under the Tertiary Care Adjustment Payments for State fiscal year 2003, as described in Section 148.296, excluding:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) Supplemental Tertiary Care Adjustment Payments
 - 1) For the supplemental tertiary care adjustment period occurring in State fiscal year 2004, total payments will equal the State fiscal year 2003 tertiary care adjustment payment, as defined in Section 148.296, multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (d) of this Section have been met.
 - 2) For the supplemental tertiary care adjustment period occurring in State fiscal year 2005, total payments will equal the State fiscal year 2003 tertiary care adjustment payment, as defined in Section 148.296 and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (d) being met, shall be paid within 75 days after the conditions described in subsection (d) have been met.
 - 3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- c) Definitions
 - 1) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.
 - 2) "Supplemental Tertiary Care Adjustment Period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30,

2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

- d) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Amended at 29 Ill. Reg. 8363, effective June 1, 2005)

Section 148.90 Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments

- a) Qualifying Criteria. Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments as described in subsection (b) of this Section shall be made to an Illinois hospital, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).
- b) MIUR Adjustment Payments
 - 1) Each qualifying hospital will receive a payment equal to the product of:
 - A) The quotient of:
 - i) \$57.25
 - ii) divided by the greater of the hospital's MIUR or 1.6 percent, and
 - B) The hospital's Medicaid inpatient days in the MIUR base period.
 - 2) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.
 - 3) Payments will be the lesser of the calculation described in subsection (b)(1) or (b)(2) of this Section or \$10,500,000.
- c) Payment to a Qualifying Hospital
 - 1) For the MIUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (e) of this Section have been met.
 - 2) For the MIUR adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described

in subsection (e) being met, shall be paid within 75 days after the conditions described in subsection (e) have been met.

- 3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

- 1) "MIUR base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.
- 2) "MIUR adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12 month period beginning July 1 of the year and ending June 30 of the following year.
- 3) "Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the MIUR base period that were adjudicated by the Department through June 30, 2002.
- 4) "MIUR", for a given hospital, has the meaning as defined in Section 148.120(k)(4) and shall be determined in accordance with Section 148.120(c) and (f). For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2003 shall be the MIUR used in the MIUR adjustment.
- 5) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.
- 6) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.

- e) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Amended at 29 Ill. Reg. 8363, effective June 1, 2005)

Section 148.95 Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments

- a) Qualifying Criteria. Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments, as described in subsection (b) of this Section, shall be made to an Illinois hospital, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).
- b) MOUR Adjustment Payments
 - 1) Each qualifying hospital will receive a payment equal to the product of:
 - A) The quotient of:
 - i) the hospital's Medicaid outpatient charges in the MOUR base period
 - ii) divided by the greater of the hospital's MOUR or 1.6 percent, and
 - B) 2.45 percent.
 - 2) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.
 - 3) Payments will be the lesser of the calculation described in subsection (b)(1) or (b)(2) of this Section or \$6,750,000.
- c) Payment to a Qualifying Hospital
 - 1) For the MOUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (e) of this Section have been met.
 - 2) For the MOUR adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15,

2005. The sum of the amounts, required prior to the conditions described in subsection (e) being met, shall be paid within 75 days after the conditions in subsection (e) have been met.

- 3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

- 1) “Total outpatient charges” means, for a given hospital, the gross outpatient revenue as reported on form CMS 2552-96, Worksheet G-2, Part I, row 25, column 2, for hospital fiscal years ending in calendar year 2001 as filed in the March 2003 release of the Healthcare Cost Reporting Information System (HCRIS). If information was not available for hospitals on the HCRIS, the Department may obtain the gross outpatient charges from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.
- 2) “MOUR base period” means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.
- 3) “MOUR adjustment period” means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12 month period beginning July 1 of the year and ending June 30 of the following year.
- 4) “MOUR”, for a given hospital, means the ratio of Medicaid outpatient charges to total outpatient charges.
- 5) “Medicaid outpatient charges” means, for a given hospital, the sum of charges for ambulatory procedure listing services as described in Section 148.140(b), excluding charges for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover charges), as tabulated from the Department’s paid claims data for services occurring in the MOUR base year that were adjudicated by the Department through September 12, 2003.
- 6) “Occupied bed days” means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital’s occupied bed

days is not reported on the Annual Survey of Hospitals, then the Department of Public Aid may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

- 7) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.
- e) Payment Limitations: Payments under this Section are not due and payable until:
 - 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Amended at 29 Ill. Reg. 8363, effective June 1, 2005)

Section 148.100 Outpatient Rural Hospital Adjustment Payments

- a) Qualifying Criteria. Outpatient Rural Hospital Adjustment Payments, as described in subsection (b) of this Section, shall be made to qualifying Illinois rural hospitals, as described in Section 148.25(g)(3), excluding:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act [110 ILCS330], as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) Outpatient Rural Hospital Adjustment Payments
 - 1) Each qualifying hospital's outpatient services for the outpatient rural base period will be divided by the sum of all qualifying hospitals' outpatient services for the outpatient rural base period.
 - 2) This ratio will be multiplied by \$14,500,000 to determine the hospital's Outpatient Rural Hospital Adjustment Payment.
 - 3) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(2) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.
- c) Payment to a Qualifying Hospital
 - 1) For the outpatient rural hospital adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (e) of this Section have been met.
 - 2) For the outpatient rural hospital adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal

installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (e) being met, shall be paid within 75 days after the conditions described in subsection (e) have been met.

- 3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

- 1) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.
- 2) "Outpatient rural base period" means the 12-month period beginning on July 1, 2000, and ending on June 30, 2001.
- 3) "Outpatient rural adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 4) "Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b), excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated from the Department's paid claims data for services occurring in the outpatient rural base period that were adjudicated by the Department through September 12, 2003.
- 5) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.

e) Payment Limitations: Payments under this Section are not due and payable until:

- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Amended at 29 Ill. Reg. 8363, effective June 1, 2005)

Section 148.103 Outpatient Service Adjustment Payments

- a) Qualifying Criteria. Outpatient Service Adjustment Payments, as described in subsection (b) of this Section, shall be made to all Illinois hospitals excluding:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) Outpatient Service Adjustment Payments
 - 1) An average hospital specific outpatient service rate for the outpatient service base period will be calculated by taking the total payments for outpatient services divided by total outpatient services.
 - 2) The average hospital specific outpatient service rate will be multiplied by 75.5 percent and then multiplied by the outpatient services.
 - 3) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(2) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.
 - 4) Outpatient Service Adjustment Payments will be the lesser of the amount determined in subsection (b)(2) or (b)(3) of this Section or \$3,000,000.
- c) Payment to a Qualifying Hospital
 - 1) For the outpatient service adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions in subsection (e) of this Section have been met.
 - 2) For the outpatient service adjustment period occurring in State fiscal year 2005, total annual payments will equal the methodologies described in

subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions in subsection (e) being met, shall be paid within 75 days after the conditions in subsection (e) have been met.

- 3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

- 1) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.
- 2) "Outpatient service base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.
- 3) "Outpatient service adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 4) "Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140 (b), excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated from the Department's paid claims data for services occurring in the outpatient service base period that were adjudicated by the Department through September 12, 2003.
- 5) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.

e) Payment Limitations: Payments under this Section are not due and payable until:

- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Amended at 29 Ill. Reg. 8363, effective June 1, 2005)

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.105 Psychiatric Adjustment Payments

a) Qualifying Criteria

Psychiatric Adjustment Payments shall be made to a qualifying hospital, as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria as of July 1, 2002:

- 1) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; and has a MIUR as described in subsection (e)(5) of this Section that is greater than 60 percent.
- 2) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) that is greater than 20 percent; has greater than 325 total licensed beds as described in subsection (e)(2) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 50 percent.
- 3) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 15 percent; has greater than 500 total licensed beds as described in subsection (e)(2) of this Section; has a psychiatric occupancy rate as described in subsection (e)(4) of this Section that is greater than 35 percent; and has total licensed psychiatric beds described in subsection (e)(3) of this Section that is greater than 50.
- 4) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled

with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 19 percent; has less than 275 total licensed beds as described in subsection (e)(2) of this Section; has fewer than 1,000 total psychiatric care days as described in subsection (e)(8) of this Section; has 40 or fewer total licensed psychiatric beds as described in subsection (e)(3) of this Section; has greater than 6,000 total days as described in subsection (e)(9) of this Section.

- 5) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the Statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has 50 or more total licensed psychiatric beds as described in subsection (e)(3) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 60 percent.
- b) The following five classes of hospitals are ineligible for Psychiatric Adjustment Payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4) of this Section:
- 1) Hospitals located outside of Illinois.
 - 2) Hospitals located inside HSA 6.
 - 3) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(c)(1).
 - 4) Long term stay hospitals, as described in 89 Ill. Adm. Code 149.50(c)(4).
 - 5) A children's hospital, as described in 89 Ill. Adm. Code 149.50(c)(3).
- c) Psychiatric Adjustment Payment Rates
- 1) For a hospital qualifying under subsection (a)(1) of this Section, the rate is \$63.00.
 - 2) For a hospital qualifying under subsection (a)(2) of this Section that:
 - A) Has less than 10,000 total days, the rate is \$78.00.

- B) Has equal to or greater than 10,000 total days, the rate is \$125.00.
 - 3) For a hospital qualifying under subsection (a)(3) of this Section, the rate is \$21.00.
 - 4) For a hospital qualifying under subsection (a)(4) of this Section, the rate is \$38.00.
 - 5) For a hospital qualifying under subsection (a)(5) of this Section, the rate is \$140.00
- d) Payment to a Qualifying Hospital
- 1) The total annual adjustment amount to a qualifying hospital shall be the product of the appropriate psychiatric adjustment payment rate, as described in subsection (c) of this Section, multiplied by total days as described in subsection (e)(9) of this Section.
 - 2) The total annual adjustment amount shall be paid to the hospital during the Psychiatric Adjustment Payment period in installments on, at least, a quarterly basis.
- e) Definitions
- 1) “HSA” means Health Service Area, as defined by the Illinois Department of Public Health.
 - 2) “Total licensed beds” means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled “Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois”.
 - 3) “Licensed psychiatric beds” means, for a given hospital, the number of psychiatric licensed beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled “Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois”.

- 4) "Psychiatric occupancy rate" means, for a given hospital, the psychiatric hospital occupancy rate as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."
- 5) "MIUR" for a given hospital, has the meaning as defined in Section 148.120(k)(5), and shall be determined in accordance with Sections 148.120(c) and (f). For purposes of this rulemaking, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment Payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for Psychiatric Adjustment Payments in the Psychiatric Adjustment Payment Period.
- 6) "Psychiatric Adjustment Payment base year" means the 12-month period beginning on July 1, 2000, and ending on June 30, 2001.
- 7) "Psychiatric Adjustment Payment period" means, beginning October 1, 2002, the nine month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003, the 12 month period beginning July 1 of the year and ending June 30 of the following year.
- 8) "Total psychiatric care days" means, for a given hospital, the sum of days of inpatient psychiatric care, as defined in Section 148.40(a), provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.
- 9) "Total days" means, for a given hospital, the sum of days of inpatient hospital services provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.
- 10) "Psychiatric care average length of stay" means the quotient of the fraction, the numerator of which is the number of psychiatric care days in the Psychiatric Adjustment Payment base year, the denominator of which

is the number of admissions in the Psychiatric Adjustment Payment base year.

(Source: Amended at 29 Ill. Reg. 19973, effective November 23, 2005)

Section 148.110 Psychiatric Base Rate Adjustment Payments

a) Qualifying Criteria

- 1) Psychiatric Base Rate Adjustment Payments, as described in subsection (b)(1) of this Section, shall be made to an Illinois general acute care hospital that has a distinct part psychiatric unit, excluding:
 - A) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - B) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).
 - C) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- 2) Psychiatric Base Rate Adjustment Payments described in subsection (b)(2) of this Section shall be made to an Illinois general acute care hospital that has a distinct part psychiatric unit, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).

b) Psychiatric Base Rate Adjustment Payments

- 1) For a hospital qualifying under subsection (a)(1) of this Section, the Department shall pay an amount equal to \$400.00 less the hospital's per diem rate for Medicaid inpatient psychiatric services in effect on October 1, 2003, multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric base rate period. In no event, however, shall that amount be less than zero.
- 2) For a hospital qualifying under subsection (a)(2) of this Section, whose inpatient psychiatric per diem rate in effect on October 1, 2003 is greater than \$400.00, the Department shall pay an amount equal to \$25.00 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric base rate period.
- 3) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) or (b)(2) shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.

- c) Payment to a Qualifying Hospital
 - 1) For the psychiatric base rate adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (f) of this Section have been met.
 - 2) For the psychiatric base rate adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (f) being met, shall be paid within 75 days after the conditions in subsection (f) have been met.
 - 3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- d) Limitations: Hospitals that qualify for Psychiatric Base Rate Adjustment Payments shall not be eligible for the total Psychiatric Base Rate Adjustment Payment if, during the psychiatric base rate adjustment period, the hospital no longer operates the psychiatric distinct part unit.
- e) Definitions
 - 1) “Psychiatric base rate period” means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.
 - 2) “Psychiatric base rate adjustment period” means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 3) “Medicaid inpatient psychiatric days” means, for a given hospital, the sum of days of inpatient psychiatric hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department’s paid claims data for admissions occurring in the psychiatric base period that were adjudicated by the Department through June 30, 2002.

- 4) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.
- 5) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.
- f) Payment Limitations: Payments under this Section are not due and payable until:
 - 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Amended at 29 Ill. Reg. 8363, effective June 1, 2005)

Section 148.112 High Volume Adjustment Payments

- a) Qualifying criteria. High Volume Adjustment Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it did not qualify for disproportionate share adjustments as described in Section 148.120 for the rate year 2003 determination and provided more than 20,000 Medicaid inpatient days in the high volume base period.
- b) The following classes of hospitals are ineligible for High Volume Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- c) High Volume Adjustment Payments
 - 1) For a hospital qualifying under subsection (a) of this Section, the Department shall pay the product of \$190.00 multiplied by the qualifying hospital's Medicaid inpatient days.
 - 2) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (c)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.
 - 3) For hospitals qualifying under subsection (a) of this Section that provided fewer than 30,000 Medicaid inpatient days in the high volume base period, payments will be the lesser of the calculation described in subsection (c)(1) or (c)(2) of this Section or \$3,500,000.
- d) Payment to a Qualifying Hospital
 - 1) For the high volume adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (c) of

this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (f) of this Section have been met.

- 2) For the high volume adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions in subsection (f) being met, shall be paid within 75 days after the conditions in subsection (f) have been met.
- 3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

- 1) “High volume base period” means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.
- 2) “High volume adjustment period” means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 3) “Medicaid inpatient days” means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department’s paid claims data for admissions occurring in the high volume base period that were adjudicated by the Department through June 30, 2002.
- 4) “Occupied bed days” means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital’s occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

- 5) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.
- f) Payment Limitations: Payments under this Section are not due and payable until:
 - 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Amended at 29 Ill. Reg. 8363, effective June 1, 2005)

Section 148.115 Rural Adjustment Payments

a) Qualifying Criteria

Rural Adjustment Payments shall be made to all qualifying general acute care hospitals that are designated as a Critical Access Hospital or a Necessary Provider, as designated by the Illinois Department of Public Health, in accordance with 42 CFR 485, Subpart F (2001), as of the first day of July in the Rural Adjustment Payment rate period.

b) Rural Adjustment Rates

1) Inpatient Component

For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment inpatient component shall be calculated as follows:

- A) Total inpatient payments, as described in subsection (d)(2) of this Section, shall be divided by the total inpatient days, as described in subsection (d)(4) of this Section, to derive an inpatient payment per day.
- B) Total inpatient charges, associated with inpatient days as described in subsection (d)(4) of this Section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(1) of this Section, to derive total inpatient cost.
- C) Total inpatient costs, as defined in subsection (b)(1)(B) of this Section, are divided by the total inpatient days, as described in subsection (d)(4) of this Section, to derive an inpatient cost per day.
- D) Inpatient payment per day, as defined in subsection (b)(1)(A) of this Section, shall be subtracted from the inpatient cost per day, as described in subsection (b)(1)(C) of this Section, to derive an inpatient cost coverage deficit per day. The minimum result shall be no lower than zero.
- E) Inpatient cost coverage deficit per day, as described in subsection (b)(1)(D) of this Section, shall be multiplied by the total inpatient days, as described in subsection (d)(4) of this Section, to derive a total hospital specific inpatient cost coverage deficit.
- F) The inpatient cost deficits, as described in subsection (b)(1)(E) of this Section, for all qualifying hospitals, shall be summed to

determine an aggregate Rural Adjustment Payment base year inpatient cost deficit.

2) Outpatient Component

For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment outpatient component shall be calculated as follows:

- A) Total outpatient payments, as defined in subsection (d)(3) of this Section, shall be divided by the total outpatient services, as described in subsection (d)(5) of this Section, to derive an outpatient payment per service unit.
- B) Total outpatient charges, associated with a patient services, as defined in subsection (d)(5) of this Section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(1) of this Section, to derive total outpatient cost.
- C) Total outpatient costs, as defined in subsection (b)(2)(B) of this Section, are divided by the total outpatient services, as described in subsection (d)(5) of this Section, to derive an outpatient cost per service unit.
- D) Outpatient payment per service unit, as defined in subsection (b)(2)(A) of this Section, shall be subtracted from the outpatient cost per service unit, as described in subsection (b)(2)(C) of this Section, to derive an outpatient cost coverage deficit per service unit. The minimum result shall be no lower than zero.
- E) Outpatient cost coverage deficit per service unit, as described in subsection (b)(2)(D) of this Section, shall be multiplied by the total outpatient services, as described in subsection (d)(5) of this Section, to derive a total hospital specific outpatient cost coverage deficit.
- F) The outpatient cost coverage deficits, as described in subsection (b)(2)(e) of this Section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year outpatient cost deficit.

3) Payment Methodology

A \$7 million total pool shall be allocated to the program, and proportioned between inpatient services and outpatient services as follows:

- A) The total inpatient cost coverage deficit, as described in subsection (b)(1)(F) of this Section, is added to the total outpatient cost coverage deficit, as described in subsection (b)(2)(F) of this Section, to derive a total Rural Adjustment Payment base year deficit.
- B) The inpatient pool allocation percentage shall be the quotient of the fraction, the numerator of which is the total inpatient cost deficit, as described in subsection (b)(1)(F) of this Section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in subsection (b)(3)(A) of this Section.
- C) The outpatient pool allocation percentage shall be the quotient of the fraction, the numerator of which is the total outpatient cost deficit, as described in subsection (b)(2)(F) of this Section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in subsection (b)(3)(A) of this Section.
- D) An inpatient pool allocation shall be the product of the inpatient pool allocation percentage, as described in subsection (b)(3)(B) of this Section, multiplied by the \$7 million pool, as described in subsection (b)(3) of this Section.
- E) The outpatient pool allocation shall be the product of the outpatient pool allocation percentage, as described in subsection (b)(3)(C) of this Section, multiplied by the \$7 million pool, as described in subsection (b)(3) of this Section.
- F) An inpatient residual cost coverage factor shall be the quotient of the fraction, the numerator of which shall be the inpatient pool allocation, as described in subsection (b)(3)(D) of this Section, the denominator of which shall be the total inpatient cost deficit as described in subsection (b)(1)(F) of this Section.
- G) An outpatient residual cost coverage factor shall be the quotient of the fraction, the numerator of which shall be the outpatient pool allocation, as described in subsection (b)(3)(E) of this Section, the denominator of which shall be the total outpatient cost deficit as described in subsection (b)(2)(F) of this Section.
- H) The hospital specific inpatient cost coverage adjustment amount shall be the product of the inpatient residual cost coverage factor, as described in subsection (b)(3)(F) of this Section, multiplied by

the hospital specific inpatient cost coverage deficit, as described in subsection (b)(1)(E) of this Section.

- I) The hospital specific outpatient cost coverage adjustment amount shall be the product of the outpatient residual cost coverage factor, as described in subsection (b)(3)(G) of this Section, multiplied by the hospital specific outpatient cost coverage deficit, as described in subsection (b)(2)(E) of this Section.

c) Payment to a Qualifying Hospital

- 1) The total annual adjustment amount to a qualified hospital shall be the sum of the hospital specific inpatient cost coverage adjustment amount, as described in subsection (b)(3)(H) of this Section, plus the hospital specific outpatient cost coverage adjustment amount, as described in subsection (b)(3)(I) of this Section.
- 2) The total annual adjustment amount shall be paid to the hospital during the Rural Adjustment Payment rate period, as described in subsection (d)(7) of this Section, on at least a quarterly basis.

d) Definitions

- 1) "Hospital cost to charge ratio" means the quotient of the fraction, the numerator of which is the cost as reported on Form CMS 2552, worksheet C, Part 1, column 1, row 101, the denominator of which is the charges as reported on Form HCFA 2552, worksheet C, Part 1, column 8, row 101. The base year for State Fiscal Year (SFY) 2003 shall be the hospital's fiscal year 1999 Medicare cost report, and, for SFY 2004, the hospital's fiscal year 2000 cost report shall be utilized. The base year for any SFY shall be determined in this manner.
- 2) "Inpatient payments" shall mean all payments associated with total days provided, as described in subsection (d)(4) of this Section, and all quarterly adjustment payments paid, as described throughout Part 148, excluding the Rural Adjustment Payments described in this Section.
- 3) "Outpatient payments" shall mean all payments associated with total outpatient services provided, as described in subsection (d)(5) of this Section, and all quarterly adjustment payments paid, as described in this Part, excluding the Rural Adjustment Payments described in this Section.
- 4) "Total days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title

XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.

- 5) "Total outpatient services" means the number of outpatient services provided during the Rural Adjustment Payment base year, to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for services occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.
- 6) "Rural Adjustment Payment base year" means, for the Rural Adjustment Payment rate period beginning October 1, 2002, SFY 2001; for the Rural Adjustment Payment rate period beginning July 1, 2003, SFY 2002. The Rural Adjustment Payment base year for subsequent rate periods shall be determined in this manner.
- 7) "Rural Adjustment Payment rate period" means, beginning October 1, 2002, the nine month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003, the 12 month period beginning July 1 of that year and ending June 30 of the following year.

(Source: Amended at 28 Ill. Reg. 15536, effective November 24, 2004)

Section 148.120 Disproportionate Share Hospital (DSH) Adjustments

Disproportionate Share Hospital (DSH) adjustments for inpatient services provided prior to October 1, 2003, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 2003, and each October 1, thereafter unless otherwise noted.

- a) Qualified Disproportionate Share Hospitals (DSH). For inpatient services provided on or after October 1, 2003, the Department shall make adjustment payments to hospitals which are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:
 - 1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in subsection (k)(4) of this Section, is at least one standard deviation above the mean Medicaid utilization rate, as defined in subsection (k)(3) of this Section.
 - 2) The hospital's low income utilization rate exceeds 25 per centum. For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance) and/or any local or State government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government-funded care) must be added.
- b) In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4), must submit a statement to that effect.

- c) In making the determination described in subsection (a)(1) of this Section, the Department shall utilize:
- 1) Hospital Cost Reports
 - A) The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in subsection (k)(4) of this Section, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.
 - B) In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsection (a)(1) of this Section. Submittal of a corrected cost report in support of subsection (a)(1) of this Section must be received or post marked no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's MIUR as described in subsection (k)(4) of this Section.
 - C) In the event of extensions to the Medicare cost report filing process, those hospitals that do not have an audited or unaudited base year Medicaid cost report on file with the Department by the 30th of April preceding the DSH determination are required to complete and submit to the Department a Hospital Day Statistics Collection (HDSC) form. On the form, hospitals must provide total Medicaid days and total hospital days for the hospital's base fiscal year. The HDSC form must be submitted to the Department by the April 30th preceding the DSH determination.
 - i) If the Medicare deadline for submitting base fiscal year cost reports falls within the month of June preceding the DSH determination, hospitals, regardless of their base fiscal year end date, will have until the first day of August preceding the DSH determination to submit changes to their Medicaid cost reports for inclusion in the final DSH

calculations. In this case, the HDSC form will not be used as a data source for the final rate year DSH determination.

- ii) If the Medicare deadline for submitting base fiscal year cost reports is extended beyond the month of June preceding the DSH determination, the HDSC form will be used in the final DSH determination for all hospitals that do not have an audited or unaudited Medicaid cost report on file with the Department. Hospitals will have until the first day of July to submit any adjustments to the information provided on the HDSC form sent to the Department on April 30.
 - D) Hospitals' Medicaid inpatient utilization rates, as defined in subsection (k)(4) of this Section, which have been derived from unaudited cost reports or the HDSC form, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsections (c)(1)(B) and (c)(1)(C)(ii) of this Section, hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH determination.
 - E) In the event a subsequent final audited cost report reflects an MIUR, as described in subsection (k)(4) of this Section, which is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report or the HDSC form utilized for the DSH determination, the Department shall recalculate the MIUR based upon the final audited cost report, and recoup any overpayments made if the percentage change in the DSH payment rate is greater than five percent.
- 2) Days Not Available from Cost Report
- Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid Health Maintenance Organization (HMO) days, hospital residing long term care days, and Medicaid days for alcohol and substance abuse rehabilitative care under category of service 35. To obtain Medicaid utilization levels in these instances, the Department shall utilize:
- A) Medicare/Medicaid Crossover Claims.

- i) For DSH determination years on or after October 1, 1996, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Provider logs as described in the following subsection (c)(3)(A)(ii) will not be used in the determination process for DSH determination years on or after October 1, 1996.
 - ii) For DSH determination years prior to October 1, 1996, hospitals may submit additional information to document Medicare/Medicaid crossover days that were not billed to the Department due to a determination that the Department had no liability for deductible or coinsurance amounts. That information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total number of Medicare/Medicaid crossover days. That log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days which were not billed to the Department for services provided during the hospital's base fiscal year. If a hospital does not submit a log of Medicare/Medicaid crossover days that meets the above requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.
- B) Out-of-state Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.
- C) HMO days. The Department will utilize the Department's HMO claims data available to the Department as of the last day of June preceding the DSH determination year, or specific claim information from each HMO, for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an HMO.

- D) Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care days provided to recipients.
 - E) Alcohol and Substance Abuse Days. The Department will utilize its paid claims data under category of service 35 available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient days provided for alcohol and substance abuse rehabilitative care.
- d) Hospitals may apply for DSH status under subsection (a)(2) of this Section by submitting an audited certified financial statement, for the hospital's base fiscal year, to the Department of Human Services or the Department of Public Aid. The statements must contain the following breakdown of information prior to submittal to the Department for consideration:
 - 1) Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.
 - 2) Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.
 - 3) Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts, except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance), for the hospital's base fiscal year.
 - 4) Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.
- e) With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois that qualify for DSH in the state in which they are located based upon the Federal definition of a DSH hospital, as defined in Section 1923(b)(1) of the Social Security Act, may qualify for DSH hospital adjustments under this Section. For purposes of determining the MIUR, as described in subsection (k)(4) of this Section and as required in Section 1923(b)(1) of the Social Security Act, out-of-state hospitals

will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not qualify by the MIUR from their state may submit an audited certified financial statement as described in subsection (d) of this Section. Payments to out-of-state hospitals will be allocated using the same method as described in subsection (g) of this Section.

- f) Time Limitation Requirements for Additional Information.
 - 1) Except as provided in subsection (c)(1)(C), the information required in subsections (a), (c), (d) and (e) of this Section must be received or post marked no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such information for the determination of DSH qualification. Information required in subsections (a), (c), (d) and (e) of this Section which is not received or post marked in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.
 - 2) The information required in subsection (b) of this Section must be submitted after receipt of notification from the Department. Information required in this Section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.
- g) Inpatient Payment Adjustments to DSH Hospitals. The adjustment payments required by subsection (a) of this Section shall be calculated annually as follows:
 - 1) Five Million Dollar Fund Adjustment for hospitals defined in Section 148.25(b)(1).
 - A) Hospitals qualifying as DSH hospitals under subsection (a)(1) or (a)(2) of this Section will receive an add-on payment to their inpatient rate.
 - B) The distribution method for the add-on payment described in subsection (g)(1) of this Section is based upon a fund of \$5 million. All hospitals qualifying under subsection (g)(1)(A) of this Section will receive a \$5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by \$5. The total dollar amount of this calculation is then subtracted from the \$5 million fund.

- C) The remaining fund balance is then distributed to the hospitals that qualify under subsection (a)(1) of this Section in proportion to the percentage by which the hospital's MIUR exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate, as described in subsection (k)(3) of this Section. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the \$5 million pool of money available after the \$5 per day base add-on has been subtracted.
 - D) The total dollar amount calculated for each qualifying hospital under subsection (g)(1)(C) of this Section, plus the initial \$5 per day add-on amount calculated for each qualifying hospital under subsection (g)(1)(B) of this Section, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at a per day add-on value. Hospitals qualifying under subsection (a)(2) of this Section will receive the minimum adjustment of \$5 per inpatient day. The adjustments calculated under this subsection (g)(1) are subject to the limitations described in subsection (j) of this Section. The adjustments calculated under subsection (g) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.
- 2) Department of Human Services (DHS) State-Operated Facility Adjustment for hospitals defined in Section 148.25(b)(6). Department of Human Services State-operated facilities qualifying under subsection (a)(2) of this Section shall receive an adjustment for inpatient services provided on or after March 1, 1995. Effective October 1, 2000, the adjustment payment shall be calculated as follows:
- A) The amount of the adjustment is based on a State DSH Pool. The State DSH Pool amount shall be the lesser of the federal DSH allotment for mental health facilities as determined in section

1923(h) of the Social Security Act, minus the estimated DSH payments to such facilities that are not operated by the State; or the result of subtracting the estimated DSH payment adjustments made under subsections (g)(1), (h) and (i) of this Section and Section 148.170(f)(2) from the aggregate DSH payment allotment as provided for in section 1923(f) of the Social Security Act.

- B) The State DSH Pool amount is then allocated to hospitals defined in Section 148.25(b)(6) that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of uncompensated care costs, from the most recent final cost report, to the sum of all qualifying hospitals' uncompensated care costs.
- C) The adjustment calculated in subsection (g)(2)(B) of this Section shall meet the limitation described in subsection (j)(4) of this Section.
- D) The adjustment calculated pursuant to subsection (g)(2)(B) of this Section, for each hospital defined in Section 148.25(b)(6) that qualifies for DSH adjustments, is then divided by four to arrive at a quarterly adjustment. This amount is subject to the limitations described in subsection (j) of this Section. The adjustment described in this subsection (g)(2)(D) shall be paid on a quarterly basis.

3) Assistance for Certain Public Hospitals

- A) The Department may make an annual payment adjustment to qualifying hospitals in the DSH determination year. A qualifying hospital is a public hospital as defined in section 701(d) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554).
- B) Hospitals qualifying shall receive an annual payment adjustment that is equal to:
 - i) A rate amount equal to the amount specified in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, section 701(d)(3)(B) for the DSH determination year;
 - ii) Divided first by Illinois' Federal Medical Assistance Percentage; and

- iii) Divided secondly by the sum of the qualified hospitals' total Medicaid inpatient days, as defined in subsection (k)(4) of this Section; and
 - iv) Multiplied by each qualified hospital's Medicaid inpatient days as defined in subsection (k)(4) of this Section.
- C) The annual payment adjustment calculated under this subsection, for each qualified hospital, will be divided by four and paid on a quarterly basis.
- D) Payment adjustments under this subsection (g)(3) shall be made without regard to subsections (j)(3) and (4) of this Section, 42 CFR 447.272, or any standards promulgated by the Department of Health and Human Services pursuant to section 701(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.
- E) In order to qualify for assistance payments under this subsection (g)(3), with regard to this payment adjustment, there must be in force an executed intergovernmental agreement between the authorized governmental body of the qualifying hospital and the Department.
- h) Hospitals Organized Under the University of Illinois Hospital Act. For a hospital and/or hospitals organized under the University of Illinois Hospital Act, as defined in Section 148.25(b)(1)(B), the payment adjustments calculated under Section 148.122 shall be considered disproportionate share adjustments.
- i) For county owned hospitals defined in Section 148.25(b)(1)(A), a portion of the payments made in accordance with Sections 148.160(f)(3) and 148.295(c)(2)(J) may be considered disproportionate share adjustments.
- j) DSH Adjustment Limitations.
 - 1) Hospitals that qualify for DSH adjustments under this Section shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues provision of nonemergency obstetrical care. The provisions of this subsection (j)(1) shall not apply to those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4) or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987. In this instance, the adjustments calculated under

subsection (g)(1) shall cease to be effective on the date that the hospital discontinued the provision of such nonemergency obstetrical care.

- 2) Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for DSH payment adjustments based upon the requirements of this Section.
 - 3) DSH Payment Adjustment. In accordance with Public Law 102-234, if the aggregate DSH payment adjustments calculated under this Section do not meet the State's final DSH Allotment as determined by the Health Care Financing Administration (HCFA), DSH payment adjustments calculated under this Section shall be adjusted to meet the State DSH Allotment. This adjustment shall first be applied to DSH payments made under subsection (g)(2) of this Section.
 - 4) Omnibus Budget Reconciliation Act of 1993 (OBRA'93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospitals' disproportionate share payments shall be made if the sum of estimated Medicaid payments (inpatient, outpatient, and disproportionate share) to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. Federal upper payment limit requirements (42 CFR 447.272) shall be considered when calculating the OBRA'93 adjustments. The adjustments shall reduce disproportionate share spending until the costs and spending (described in this subsection (j)(4)) are equal or until the disproportionate share payments are reduced to zero. In this calculation, persons without insurance costs do not include contractual allowances. Hospitals qualifying for DSH payment adjustments must submit the information required in Section 148.150.
 - 5) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's MIUR, as defined in subsection (k)(4) of this Section, is less than one percent.
- k) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

- 1) "Base fiscal year" means, for example, the hospital's fiscal year ending in 2001 for the October 1, 2003 DSH determination year, the hospital's fiscal year ending in 2002 for the October 1, 2004 DSH determination year, etc.
- 2) "DSH determination year" means the 12 month period beginning on October 1 of the year and ending September 30 of the following year.
- 3) "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 USC 1396a et seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) but does include the types of days described in subsections (c)(1) and (c)(2) of this Section. In this subsection (k)(3), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.
- 4) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12 month period to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 USC 1396a et. seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) but does include the types of days described in subsections (c)(1) and (c)(2) of this Section. In this subsection (k)(4), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(Source: Amended at 28 Ill. Reg. 2770, effective February 1, 2004)

Section 148.122 Medicaid Percentage Adjustments

The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 2003, and each October 1 thereafter unless otherwise noted.

- a) Qualified Medicaid Percentage Hospitals. For inpatient services provided on or after October 1, 2003, the Department shall make adjustment payments to hospitals that are deemed as a Medicaid percentage hospital by the Department. A hospital may qualify for a Medicaid Percentage Adjustment in one of the following ways:
 - 1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in Section 148.120(k)(4), is at least one-half standard deviation above the mean Medicaid utilization rate, as defined in Section 148.120(k)(3).
 - 2) The hospital's low income utilization rate exceeds 25 per centum. For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance) and/or any local or State government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government-funded care) must be added.
 - 3) Illinois hospitals that, on July 1, 1991, had an MIUR, as defined in Section 148.120(k)(4), that was at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(3), and that were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (42 CFR 5 (1989)).
 - 4) Illinois hospitals that:
 - A) Have an MIUR, as defined in Section 148.120(k)(4), that is at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(3); and
 - B) Have a Medicaid obstetrical inpatient utilization rate, as defined in subsection (h)(3) of this Section, that is at least one standard

deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (h)(2) of this Section.

- 5) Any children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3).
- 6) Out of state hospitals meeting the criteria in Section 148.120 (e).
- b) In making the determination described in subsections (a)(1) and (a)(4)(A) of this Section, the Department shall utilize the data described in Section 148.120(c) and received in compliance with Section 148.120(f).
- c) Hospitals may apply to become a qualified Medicaid Percentage Adjustment hospital under subsection (a)(2) of this Section by submitting audited certified financial statements as described in Section 148.120(d) and received in compliance with Section 148.120(f).
- d) Medicaid Percentage Adjustments. The adjustment payments required by subsection (a) of this Section for qualified hospitals shall be calculated annually as follows for hospitals defined in Section 148.25(b)(1), excluding hospitals defined in Section 148.25(b)(1)(A).
 - 1) The payment adjustment shall be calculated based upon the hospital's MIUR, as defined in Section 148.120(k)(4), and subject to subsections (e) and (f) of this Section, as follows:
 - A) Hospitals with an MIUR below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$25;
 - B) Hospitals with an MIUR that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$25 plus \$1 for each one percent that the hospital's MIUR exceeds the mean Medicaid inpatient utilization rate;
 - C) Hospitals with an MIUR that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$40 plus \$7 for each one percent that the hospital's MIUR exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and

- D) Hospitals with an MIUR that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$90 plus \$2 for each one percent that the hospital's MIUR exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.
- 2) For a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), the amount calculated pursuant to subsection (d)(1) of this Section shall be increased by \$60 per day.
 - 3) The Medicaid Percentage Adjustment payment, calculated in accordance with this subsection (d), to a hospital, other than a hospital and/or hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), shall not exceed \$155 per day for a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), and shall not exceed \$215 per day for all other hospitals.
 - 4) The amount calculated pursuant to subsections (d)(1) through (d)(3) of this Section shall be adjusted by the aggregate annual increase in the national hospital market basket price proxies (DRI) hospital cost index from DSH determination year 1993, as defined in Section 148.120(k)(2), through DSH determination year 2003, and annually thereafter, by a percentage equal to the lesser of:
 - A) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or
 - B) The percentage increase in the Statewide average hospital payment rate, as described in subsection (h)(5) of this Section, over the previous year's Statewide average hospital payment rate.
 - 5) The amount calculated pursuant to subsections (d)(1) through (d)(4) of this Section, as adjusted pursuant to subsections (e) and (f) of this Section, shall be the inpatient payment adjustment in dollars for the applicable Medicaid percentage determination year. The adjustments calculated under subsections (d)(1) through (d)(4) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.

- e) Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), the payment adjustment calculated under subsection (d)(1) of this Section shall be multiplied by 2.0.
- f) Inpatient Adjustor for Hospitals Organized under the University of Illinois Hospital Act. For a hospital or hospitals organized under the University of Illinois Hospital Act, as defined in Section 148.25(b)(1)(B), the payment adjustment calculated under subsection (d)(2) of this Section shall be multiplied by 1.50.
- g) Medicaid Percentage Adjustment Limitations.
 - 1) In addition, to be deemed a Medicaid Percentage Adjustment hospital, a hospital must provide to the Department, in writing, the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the federal Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age, or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4), must submit a statement to that effect.
 - 2) Hospitals that qualify for Medicaid Percentage Adjustments under this Section shall not be eligible for the total Medicaid Percentage Adjustment if, during the Medicaid Percentage Adjustment determination year, the hospital discontinues provision of nonemergency obstetrical care. The provisions of this subsection (g)(2) shall not apply to those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4) or those hospitals that have not offered nonemergency obstetrical services as of December 22, 1987. In this instance, the adjustments calculated under subsection (d) shall cease to be effective on the date that the hospital discontinued the provision of such nonemergency obstetrical care.
 - 3) Appeals based upon a hospital's ineligibility for Medicaid Percentage payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility

for Medicaid Percentage payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the Medicaid Percentage status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for Medicaid Percentage payment adjustments based upon the requirements of this Section.

- 4) **Medicaid Inpatient Utilization Rate Limit.** Hospitals that qualify for Medicaid percentage payment adjustments under this Section shall not be eligible for Medicaid percentage payment adjustments if the hospital's MIUR, as defined in Section 148.120(k)(4), is less than one percent.
- h) **Inpatient Payment Adjustment Definitions.** The definitions of terms used with reference to calculation of Inpatient Payment Adjustments are as follows:
 - 1) "Medicaid Percentage determination year" means the 12 month period beginning on October 1 of the year and ending September 30 of the following year.
 - 2) "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (h)(4) of this Section, provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid inpatient days, as defined in subsection (h)(6) of this Section, for all such hospitals. That information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.
 - 3) "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (h)(4) of this Section, provided by a Medicaid-participating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (h)(6) of this Section, provided by such hospital. This information shall be derived from claims for applicable services provided

in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base.

- 4) "Medicaid (Title XIX) obstetrical inpatient days" means hospital inpatient days that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage Adjustment determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, with a Diagnosis Related Grouping (DRG) of 370 through 375, and specifically excludes Medicare/Medicaid crossover claims.
- 5) "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).
- 6) "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (h)(2) and (h)(3) of this Section, means hospital inpatient days, excluding days for normal newborns, that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.
- 7) "Medicaid obstetrical inpatient utilization rate base year" means, for example, fiscal year 2002 for the October 1, 2003, Medicaid Percentage Adjustment determination year; fiscal year 2003 for the October 1, 2004, Medicaid Percentage Adjustment determination year; etc.

(Source: Added at 28 Ill. Reg. 2770, effective February 1, 2004)

Section 148.126 Safety Net Adjustment Payments
EMERGENCY

- a) Qualifying criteria: Safety net adjustment payments shall be made to a qualifying hospital, as defined in this subsection (a) unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006. A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria:
- 1) The hospital has, as provided in subsection (e)(6) of this Section, an MIUR equal to or greater than 40 percent.
 - 2) The hospital has the highest number of obstetrical care days in the safety net hospital base year.
 - 3) The hospital is, as of October 1, 2001, a sole community hospital, as defined by the United States Department of Health and Human Services (42 CFR 412.92).
 - 4) The hospital is, as of October 1, 2001, a rural hospital, as described in Section 148.25(g)(3), that meets all of the following criteria:
 - A) Has an MIUR greater than 33 percent.
 - B) Is designated a perinatal level two center by the Illinois Department of Public Health.
 - C) Has fewer than 125 licensed beds.
 - 5) The hospital is a rural hospital, as described in Section 148.25(g)(3).
 - 6) The hospital meets all of the following criteria:
 - A) Has an MIUR greater than 30 percent.
 - B) Had an occupancy rate greater than 80 percent in the safety net hospital base year.
 - C) Provided greater than 15,000 total days in the safety net hospital base year.

- 7) The hospital meets all of the following criteria:
 - A) Does not already qualify under subsections (a)(1) through (a)(6) of this Section.
 - B) Has an MIUR greater than 25 percent.
 - C) Had an occupancy rate greater than 68 percent in the safety net hospital base year.
 - D) Provided greater than 12,000 total days in the safety net hospital base year.
- 8) The hospital meets all of the following criteria in the safety net base year:
 - A) Is a rural hospital, as described in Section 148.25 (g)(3).
 - B) Has an MIUR greater than 18 percent.
 - C) Has a combined MIUR greater than 45 percent.
 - D) Has licensed beds less than or equal to 60.
 - E) Provided greater than 400 total days.
 - F) Provided fewer than 125 obstetrical care days.
- 9) The hospital meets all of the following criteria in the safety net base year:
 - A) Is a psychiatric hospital, as described in 89 Ill. Adm. Code 149.50(c)(1).
 - B) Has licensed beds greater than 120.
 - C) Has an average length of stay less than ten days.
- 10) The hospital meets all of the following criteria in the safety net base year:
 - A) Does not already qualify under subsections (a)(1) through (a)(9) of this Section.

- B) Has an MIUR greater than 17 percent.
 - C) Has licensed beds greater than 450.
 - D) Has an average length stay less than four days.
- 11) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(10) of this Section.
 - B) Has an MIUR greater than 21 percent.
 - C) Has licensed beds greater than 350.
 - D) Has an average length of stay less than 3.15 days.
- 12) The hospital meets all of the following criteria in the safety net base year:
- A) Does not qualify under subsections (a)(1) through (a)(11) of this Section.
 - B) Has an MIUR greater than 34 percent.
 - C) Has licensed beds greater than 350.
 - D) Is designated a perinatal level two center by the Illinois Department of Public Health.
- 13) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(12) of this Section.
 - B) Has an MIUR greater than 35 percent.
 - C) Has an average length of stay less than four days.
- 14) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(13) of this Section.

- B) Has a CMIUR greater than 25 percent.
 - C) Has an MIUR greater than 12 percent.
 - D) Is designated a perinatal level two center by the Illinois Department of Public Health.
 - E) Has licensed beds greater than 400.
 - F) Has an average length of stay less than 3.5 days.
- b) The following five classes of hospitals are ineligible for safety net adjustment payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4), subsections (a)(6) through (a)(8), and subsections (a)(10) through (a)(14) of this Section:
- 1) Hospitals located outside of Illinois.
 - 2) County-owned hospitals, as described in Section 148.25(b)(1)(A).
 - 3) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 4) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(c)(1).
 - 5) Long term stay hospitals, as described in 89 Ill. Adm. Code 149.50(c)(4).
- c) Safety Net Adjustment Rates
- 1) For a hospital qualifying under subsection (a)(1) of this Section, the rate is the sum of the amounts for each of the following criteria for which it qualifies:
 - A) A qualifying hospital-\$15.00.
 - B) A rehabilitation hospital, as described in 89 Ill. Adm. Code 149.50(c)(2)-\$20.00.
 - C) A children's hospital, as described in 89 Ill. Adm. Code 149.50(c)(3)-\$20.00.

- D) A children's hospital that has an MIUR greater than or equal to 80 per centum that is:
 - i) Located within HSA 6 or HSA 7-\$296.00.
 - ii) Located outside HSA 6 or HSA 7-\$35.00.
- E) A children's hospital that has an MIUR less than 80 per centum, but greater than or equal to 60 per centum, that is:
 - i) Located within HSA 6 or HSA 7-\$35.00.
 - ii) Located outside HSA 6 or HSA 7-\$15.00.
- F) A children's hospital that has an MIUR less than 60 per centum, but greater than or equal to 45 per centum, that is:
 - i) Located within HSA 6 or HSA 7-\$12.00.
 - ii) Located outside HSA 6 or HSA 7-\$5.00.
- G) A children's hospital with more than 25 graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory"-\$125.00.
- H) A children's hospital that is a rural hospital-\$145.00.
- I) A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital; that is located in HSA 6 and that:
 - i) Provides obstetrical care-\$10.00.
 - ii) Has at least one graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory"-\$5.00.
 - iii) Has at least one obstetrical graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory"-\$5.00.
 - iv) Provided more than 5,000 obstetrical days during the safety net hospital base year-\$35.00.

- v) Provided fewer than 4,000 obstetrical days during the safety net hospital base year and its average length of stay is: less than or equal to 4.50 days-\$5.00; less than 4.00 days-\$5.00; less than 3.75 days-\$5.00.
 - vi) Provides obstetrical care and has an MIUR greater than 65 percent-\$11.00.
 - vii) Has greater than 700 licensed beds-\$37.75.
 - J) A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital, that is located outside HSA 6, that has an MIUR greater than 50 per centum, and that:
 - i) Provides obstetrical care-\$70.00.
 - ii) Does not provide obstetrical care-\$30.00.
 - iii) Is a trauma center, recognized by the Illinois Department of Public Health (IDPH), as of July 1, 2005-\$173.50.
 - K) A qualifying hospital that provided greater than 35,000 total days in the safety net hospital base year-\$6.00.
 - L) A qualifying hospital with two or more graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory", with an average length of stay fewer than 4.00 days-\$48.00.
- 2) For a hospital qualifying under subsection (a)(2) of this Section, the rate shall be \$123.00.
- 3) For a hospital qualifying under subsection (a)(3) of this Section, the rate is the sum of the amounts for each of the following criteria for which it qualifies:
- A) A qualifying hospital-\$40.00.
 - B) A hospital that has an average length of stay of fewer than 4.00 days, and:

- i) More than 150 licensed beds-\$20.00.
 - ii) Fewer than 150 licensed beds-\$40.00.
 - C) A qualifying hospital with the lowest average length of stay-\$15.00.
 - D) A hospital that has a CMIUR greater than 65 per centum-\$35.00.
 - E) A hospital that has fewer than 25 total admissions in the safety net hospital base year-\$160.00.
- 4) For a hospital qualifying under subsection (a)(4) of this Section, the rate shall be \$55.00.
- 5) For a hospital qualifying under subsection (a)(5) of this Section, the rate is the sum of the amounts for each of the following for which it qualifies, divided by the hospital's total days:
- A) The hospital that has the highest number of obstetrical care admissions-\$30,840.00.
 - B) The greater of:
 - i) The product of \$115.00 multiplied by the number of obstetrical care admissions.
 - ii) The product of \$11.50 multiplied by the number of general care admissions.
- 6) For a hospital qualifying under subsection (a)(6) of this Section, the rate is \$53.00.
- 7) For a hospital qualifying under subsection (a)(7) of this Section, the rate is \$175.50.
- 8) For a hospital qualifying under subsection (a)(8) of this Section, the rate is \$124.50.
- 9) For a hospital qualifying under subsection (a)(9) of this Section, the rate is \$85.50.

- 10) For a hospital qualifying under subsection (a)(10) of this Section, the rate is \$13.75.
 - 11) For a hospital qualifying under subsection (a)(11) of this Section, the rate is \$39.50.
 - 12) For a hospital qualifying under subsection (a)(12) of this Section, the rate is \$120.25.
 - 13) For a hospital qualifying under subsection (a)(13) of this Section, the rate is \$231.50.
 - 14) For a hospital qualifying under subsection (a)(14) of this Section, the rate is \$172.00.
- d) Payment to a Qualifying Hospital
- 1) The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by two multiplied by total days.
 - 2) For the safety net adjustment period occurring in State fiscal year 2006, total payments will equal the methodologies described in subsection (c) of this Section. For the period October 1, 2005 through June 30, 2006, payment will equal the State fiscal year 2006 amount less the amount the hospital received under the safety net adjustment period for the quarter ending September 30, 2005.
 - 3) For safety net adjustment periods occurring after State fiscal year 2006, total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital during the safety net adjustment period in installments on, at least, a quarterly basis.
- e) Definitions
- 1) "Average length of stay" means, for a given hospital, a fraction in which the numerator is the number of total days and the denominator is the number of total admissions.
 - 2) "CMIUR" means, for a given hospital, the sum of the MIUR plus the Medicaid obstetrical inpatient utilization rate, determined as of October 1, 2001, as defined in Section 148.120(k)(6).

- 3) “General care admissions” means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, as tabulated from the Department’s claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department by June 30, 2001, excluding admissions for: obstetrical care, as defined in subsection (e)(7) of this Section; normal newborns; psychiatric care; physical rehabilitation; and those covered in whole or in part by Medicare (Medicaid/Medicare crossover admissions).
- 4) “HSA” means Health Service Area, as defined by the Illinois Department of Public Health.
- 5) “Licensed beds” means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled “Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois.”
- 6) “MIUR”, for a given hospital, has the meaning as defined in Section 148.120(k)(5) and shall be determined in accordance with Section 148.120(c) and (f). For purposes of this Section, the MIUR determination that was used to determine a hospital’s eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2002 shall be the same determination used to determine a hospital’s eligibility for safety net adjustment payments in the Safety Net Adjustment Period.
- 7) “Obstetrical care admissions” means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, as tabulated from the Department’s claims data, for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001, and were assigned by the Department a diagnosis related grouping (DRG) code of 370 through 375.
- 8) “Obstetrical care days” means, for a given hospital, days of hospital inpatient service associated with the obstetrical care admissions described in subsection (e)(7) of this Section.
- 9) “Occupancy rate” means a fraction, the numerator of which is the hospital’s total days, excluding long term care and substance abuse days, and the denominator of which is the hospital’s total beds, excluding long

term care and substance abuse beds, multiplied by 365 days. The data used for calculation of the hospital occupancy rate is as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."

- 10) "Safety net hospital base year" means the 12-month period beginning on July 1, 1999, and ending on June 30, 2000.
- 11) "Safety net adjustment period" means, beginning July 1, 2002, the 12 month period beginning on July 1 of a year and ending on June 30 of the following year.
- 12) "Total admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover admissions), as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.
- 13) "Total days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 11815, effective July 1, 2006, for a maximum of 150 days)

Section 148.130 Outlier Adjustments for Exceptionally Costly Stays

- a) Outlier Adjustments. Outlier adjustments are provided for exceptionally costly stays provided by hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Section 148.82(g).
- b) The determination of those services qualified for an outlier adjustment shall be made as follows for services provided on and after October 1, 1992, and for each subsequent rate period, as defined in Section 148.25(g)(2)(B), for hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Section 148.82(g):
 - 1) The services must have been provided on or after October 1, 1992; and
 - 2) The services must have been provided to:
 - A) Children who have not attained the age of six years by hospitals defined by the Department as DSH hospitals under Section 148.120(a); or
 - B) Infants who have not attained the age of one year by hospitals that do not meet the definition of a DSH hospital under Section 148.120(a).
 - 3) Claims with total covered charges equal to or above the mean total covered charges plus one standard deviation shall be considered for outlier adjustments once the following calculations have been performed:
 - A) Total covered charges (less charges attributable to medical education) equal to or exceeding one standard deviation above the mean shall be multiplied by the hospital's cost to charge ratio.
 - B) The hospital's rate for services provided on the claim shall be multiplied by the number of covered days on the claim.
 - C) The product of subsection (3)(B) above shall be subtracted from the product of (A) above.
 - D) The difference of subsection (3)(C) above shall be multiplied by .25, the product of which shall be the outlier adjustment for the claim.
 - E) Third party payments (credits) shall be applied to the final payment made on the claim.
- c) The determination of those services qualified for an outlier adjustment shall be made in accordance with 89 Ill. Adm. Code 149.105 for hospitals reimbursed on a per case basis.
- d) Definition of terms relating to outlier adjustments are as follows:
 - 1) "Base fiscal year" means the hospital's fiscal year cost report most recently audited by the Department.
 - 2) "Cost to Charge Ratio" means the hospital's Medicaid total allowable cost for all care divided by the Medicaid total covered charges for all care. The

Cost to Charge Ratio is derived by utilizing cost report data from the hospital's base fiscal year.

- 3) "Mean total covered charges" means the mean total covered charges (as described in subsection (5) below), for services provided in the most recent state fiscal year for which complete information is available and which have been adjudicated by the Department, as follows:
 - A) For hospitals that do not meet the definition of a DSH hospital under Section 148.120(a) in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of one year; and
 - B) For hospitals defined by the Department as DSH hospitals under Section 148.120(a) in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of six years.
- 4) "Rate for services provided" means the inpatient rate in effect for the type of services provided.
- 5) "Total covered charges" means the amount entered on the UB-82 or UB-92 Uniform Billing Form for revenue code 001 in column 53 (Total Charges).

(Source: Amended at 19 Ill. Reg. 10060, effective June 29, 1995)

Section 148.140 Hospital Outpatient and Clinic Services

a) Fee-For-Service Reimbursement

- 1) Reimbursement for hospital outpatient services shall be made on a fee-for-service basis, except for:
 - A) Those services that meet the definition of the Ambulatory Procedure Listing (APL) as described in subsection (b) of this Section.
 - B) End stage renal disease treatment (ESRDT) services, as described in subsection (c) of this Section.
 - C) Those services provided by a Certified Pediatric Ambulatory Care Center (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D).
 - D) Those services provided by a Critical Clinic Provider as described in subsection (e) of this Section.
- 2) Except for the procedures under the APL groupings described in subsection (b) of this Section, fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.
- 3) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rate described in subsection (a)(2) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
 - A) The reimbursement rates described in subsection (a)(2) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 4) Maternal and Child Health Program rates, as described in 89 Ill. Adm. Code 140 Table M, shall be paid to Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A) and Section 148.25(b)(5)(A), Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and Section 148.25(b)(5)(B), and Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C), and Section 148.25(b)(5)(C). Maternal and Child Health Program rates shall also be paid to Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), for covered services as described in 89 Ill. Adm. Code 140.462(e)(3), that are provided to non-assigned Maternal and Child Health Program clients, as described in 89 Ill. Adm. Code 140.464(b)(1).
- 5) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b)(2) for assigned clients.
- 6) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- 7) With the exception of the retrospective adjustment described in subsection (a)(3) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this Section.
- b) Ambulatory Procedure Listing (APL)
Effective January 1, 2006, the Department will reimburse hospitals for certain hospital outpatient procedures as described in subsection (b)(1) of this Section.
 - 1) APL Groupings
Under the APL, a list was developed that defines those technical procedures that require the use of the hospital outpatient setting, its technical staff or equipment. These procedures are separated into separate

groupings based upon the complexity and historical costs of the procedures. The groupings are as follows:

A) Surgical Groups

- i) Surgical group 1(a) consists of intense surgical procedures. Group 1(a) surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills and highly technical operating room personnel using high technology equipment. The rate for this procedure shall be \$1,794.00.
- ii) Surgical group 1(b) consists of moderately intense surgical procedures. Group 1(b) surgeries generally require the use of an operating room suite or an emergency room treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment. The rate for this procedure shall be \$1,049.00.
- iii) Surgical group 1(c) consists of low intensity surgical procedures. Group 1(c) surgeries may be done in an operating suite or an emergency room and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons. The rate for this procedure shall be \$752.00.
- iv) Surgical group 1(d) consists of surgical procedures of very low intensity. Group 1(d) surgeries may be done in an operating room or emergency room, have a low risk of complications, and include some physician-administered diagnostic and therapeutic procedures. The rate for this procedure shall be \$287.00.

B) Diagnostic and Therapeutic Groups

- i) Diagnostic and therapeutic group 2(a) consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2(a) procedures are typically invasive and must be administered by a physician. The rate for this procedure shall be \$941.00.

- ii) Diagnostic and therapeutic group 2(b) consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. Group 2(b) procedures typically include radiological consultation or a diagnostic study. The rate for this procedure shall be \$304.00.
 - iii) Diagnostic and therapeutic group 2(c) consists of other diagnostic tests. Group 2(c) procedures are generally non-invasive and may be administered by a technician and monitored by a physician. The rate for this procedure shall be \$176.00.
 - iv) Diagnostic and therapeutic group 2(d) consists of therapeutic procedures. Group 2(d) procedures typically involve parenterally administered therapeutic agents. Either a nurse or a physician is likely to perform such procedures. The rate for this procedure shall be \$136.00.
- C) Group 3 reimbursement for services provided in a hospital emergency department will be made in accordance with one of the three levels described in this Section. Emergency Services mean those services that are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The determination of the level of service reimbursable by the Department shall be based upon the circumstances at the time of the initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.
- i) Emergency Level I refers to Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries that pose an immediate significant threat to life or physiologic function or requires an intense level of physician or nursing intervention. An "intense

level” is defined as more than two hours of documented one-on-one nursing care or interactive treatment. The rate for this service shall be \$181.00.

- ii) Emergency Level II refers to Emergency Services that do not meet the definition in this Section of Emergency Level I care, but that are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity. The rate for this service shall be \$67.00.
- iii) Non-Emergency/Screening Level means those services provided in the hospital emergency department that do not meet the requirements of Emergency Level I or II stated in this Section. For such care, the Department will reimburse the hospital either applicable current FFS rates for the services provided or a screening fee, but not both. The rate for this service shall be \$26.00.

D) Group 4 for observation services is established to reimburse such services that are provided when a patient’s current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting that provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. The hospital may bill for both observation and other APL procedures but will be reimbursed only for the procedure (group) with the highest reimbursement rate. Observation services will be reimbursed under one of three categories:

- i) for at least 60 minutes but less than six hours and 31 minutes of services, the rate shall be \$74.00;
- ii) for at least six hours and 31 minutes but less than 12 hours and 31 minutes of services, the rate shall be \$222.00; or
- iii) for at least 12 hours and 31 minutes or more of services, the rate shall be \$443.00.

E) Group 5 for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to

provide inpatient psychiatric services. Under this group, the Department will reimburse, at different rates, Type A and Type B Psychiatric Clinic Services, as defined in Section 148.40(d)(1). A different rate will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. Code 149.50 (c)(3)(A).

- i) The rate for Type A psychiatric clinic services shall be \$68.00.
- ii) The rate for Type A psychiatric clinic services provided by a Children's Hospital shall be \$102.00.
- iii) The rate for Type B psychiatric clinic services shall be \$101.00.
- iv) The rate for Type B psychiatric clinic services provided by a Children's Hospital shall be \$102.00.

F) Group 6 for physical rehabilitation services is established to reimburse for certain outpatient physical rehabilitation services. Under this group, the Department will reimburse for services provided by a hospital enrolled with the Department to provide outpatient physical rehabilitation services at a different rate than will be reimbursed for physical rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation services. A different rate will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).

- i) The rate for rehabilitation services provided by a hospital enrolled with the Department to provide outpatient physical rehabilitation shall be \$130.00.
- ii) The rate for rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation shall be \$115.00.
- iii) The rate for rehabilitation services provided by Children's Hospitals shall be \$130.00.

- 2) Each of the groups described in subsection (b)(1) of this Section will be reimbursed by the Department considering the following:

- A) The Department will provide cost outlier payments for specific devices and drugs associated with specific APL procedures. Such payments will be made if:
 - i) The device or drug is on an approved list maintained by the Department. In order to be approved, the Department will consider requests from medical providers and shall base its decision on medical appropriateness of the device or drug and the costs of such device or drug; and
 - ii) The provision of such devices or drugs is deemed to be medically appropriate for a specific client, as determined by the Department's physician consultants.
- B) Additional payment for such devices or drugs, as described in subsection (b)(2)(A) of this Section, will require prior authorization by the Department unless it is determined by the Department's professional medical staff that prior authorization is not warranted for a specific device or drug. When such prior authorization has been denied for a specific device or drug, the decision may be appealed as allowed by 89 Ill. Adm. Code 102.80(a)(7) and in accordance with the provisions for assistance appeals at 89 Ill. Adm. Code 104.
- C) The amount of additional payment for devices or drugs, as described in subsection (b)(2)(A) of this Section, will be based on the following methodology:
 - i) The product of a cost to charge ratio that, in the case of cost reporting hospitals as described in Section 148.130(d), or in the case of other non-cost reporting providers, equals 0.5 multiplied by the provider's total covered charges on the qualifying claim, less the APL payment rate multiplied by four;
 - ii) If the result of subsection (b)(2)(C)(i) of this Section is less than or equal to zero, no additional payment will be made. If the result is greater than zero, the additional payment will equal the result of subsection (b)(2)(C)(i) of this Section, multiplied by 80 percent. In such cases, the provider will

receive the sum of the APL payment and the additional payment for such high cost devices or drugs.

- D) For county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be equal to the amounts described in subsection (b)(1) of this Section multiplied by a factor of 2.72, except that physical rehabilitation services provided by a general care hospital not enrolled with the Department to provide outpatient physical rehabilitation services shall be reimbursed at a rate of \$230.00 and the reimbursement rate for Type B psychiatric clinic services shall be \$224.00.
 - E) Reimbursement rates for hospitals not required to file an annual cost report with the Department may be lower than those listed in this Section.
 - F) Reimbursement for each APL group described in this subsection (b) shall be all-inclusive for all services provided by the hospital, regardless of the amount charged by a hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional outpatient services of a physician providing direct patient care who is salaried by the hospital, and occupational or speech therapy services provided in conjunction with rehabilitation services as described in subsection (b)(1)(F) of this Section. For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.
- 3) The assignment of procedure codes to each of the reimbursement groups in subsection (b)(1) of this Section are detailed in the Department's Hospital Handbook and in notices to providers.

- 4) A one-time fiscal year 2000 payment will be made to hospitals. Payment will be based upon the services, specified in this Section, provided on or after July 1, 1998, and before July 1, 1999, which were submitted to the Department and determined eligible for payment (adjudicated) by the Department on or prior to April 30, 2000, excluding services for Medicare/Medicaid crossover claims and claims which resulted in a zero payment by the Department. A one-time amount of:
- A) \$27.75 will be paid for each service for procedure code W7183 (Psychiatric clinic Type A for adults).
 - B) \$24.00 will be paid for each service for APL Group 5 (Psychiatric clinic Type A only) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
 - C) \$15.00 will be paid for each service for APL Group 6 (Physical rehabilitation services) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
- 5) County Facility Outpatient Adjustment
- A) Effective for services provided on or after July 1, 1995, county owned hospitals in an Illinois county with a population of over three million shall be eligible for a county facility outpatient adjustment payment. This adjustment payment shall be in addition to the amounts calculated under this Section and are calculated as follows:
 - i) Beginning with July 1, 1995, hospitals under this subsection shall receive an annual adjustment payment equal to total base year hospital outpatient costs trended forward to the rate year minus total estimated rate year hospital outpatient payments, multiplied by the resulting ratio derived when the value 200 is divided by the quotient of the difference between total base year hospital outpatient costs trended forward to the rate year and total estimated rate year hospital outpatient payments divided by one million.
 - ii) The payment calculated under this subsection (b)(5)(A) may be adjusted by the Department to ensure compliance

with aggregate and hospital specific federal payment limitations.

- iii) The county facility outpatient adjustment under this subsection shall be made on a quarterly basis.

B) **County Facility Outpatient Adjustment Definition.** The definitions of terms used with reference to calculation of the county facility outpatient adjustment are as follows:

- i) "Base Year" means the most recently completed State fiscal year.
- ii) "Rate Year" means the State fiscal year during which the county facility adjustment payments are made.
- iii) "Total Estimated Rate Year Hospital Outpatient Payments" means the Department's total estimated outpatient date of service liability, projected for the upcoming rate year.
- iv) "Total Hospital Outpatient Costs" means the statewide sum of all hospital outpatient costs derived by summing each hospital's outpatient charges derived from actual paid claims data multiplied by the hospital's cost-to-charge ratio.

6) **No Year-End Reconciliation**

With the exception of the retrospective rate adjustment described in subsection (b)(8) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (b).

7) **Rate Adjustments**

With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in subsection (b)(5) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

- A) The reimbursement rates described in subsection (b)(5) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 8) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals reimbursed under the Ambulatory Care Program in the same manner as to encounter rate hospitals and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.
- 9) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- c) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) shall be made at the Department's payment rates, as follows:
 - 1) For inpatient hospital services provided pursuant to Section 148.40(c)(1), the Department shall reimburse hospitals pursuant to Sections 148.240 through 148.300 and 89 Ill. Adm. Code 149.
 - 2) For outpatient services or home dialysis treatments provided pursuant to Section 148.40(c)(2) or (c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate which will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.2163 (1994). This rate will be that rate established by Medicare pursuant to 42 CFR 405.2124 and 413.170 (1994).
 - 3) Payment for non-routine services. For services which are provided during outpatient or home dialysis treatment pursuant to Section 148.40(c)(2) or (c)(3) but are not defined as a routine service under 42 CFR 405.2163 (1994), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.450, and 140.475 through 140.481, respectively.

- 4) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.
 - 5) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in this subsection (c) shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
 - A) The reimbursement rates described in this subsection (c) shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
 - B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
 - 6) With the exception of the retrospective rate adjustment described in subsection (c)(5) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (c).
 - 7) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) of this Section shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- d) Non Hospital-Based Clinic Reimbursement
- 1) County-Operated Outpatient Facility Reimbursement
Reimbursement for all services provided by county-operated outpatient facilities, as described in Section 148.25(b)(2)(C), that do not qualify as either a Maternal and Child Health Program managed care clinics, as described in 89 Ill. Adm. Code 140.461(f), or as a Critical Clinic Provider, as described in subsection (e) of this Section, shall be on an all-inclusive per encounter rate basis as follows:
 - A) Base Rate. The per encounter base rate shall be calculated as follows:

- i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.
- ii) The resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section, shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.
- iii) The resulting product, as calculated in subsection (d)(1)(A)(ii) of this Section, shall be added to the resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section to determine the per encounter base rate.
- iv) The resulting sum, as calculated in subsection (d)(1)(A)(iii) of this Section, shall be the per encounter base rate.

B) Supplemental Rate

- i) The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.
- ii) The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.
- iii) The quotient derived in subsection (d)(1)(B)(i) of this Section shall be added to the product derived in subsection (d)(1)(B)(ii) of this Section, to determine the per encounter supplemental rate.
- iv) The resulting sum, as described in subsection (d)(1)(B)(iii) of this Section, shall be the per encounter supplemental rate.

C) Final Rate

- i) The per encounter base rate, as described in subsection (d)(1)(A)(iv) of this Section, shall be added to the per encounter supplemental rate, as described in subsection

- (d)(1)(B)(iv) of this Section, to determine the per encounter final rate.
- ii) The resulting sum, as determined in subsection (d)(1)(C)(i) of this Section, shall be the per encounter final rate.
 - iii) The per encounter final rate, as described in subsection (d)(1)(C)(ii) of this Section, shall be adjusted in accordance with subsection (d)(2) of this Section.
- 2) Rate Adjustments
- Rate adjustments to the per encounter final rate, as described in subsection (d)(1)(C)(iii) of this Section, shall be calculated as follows:
- A) The reimbursement rates described in subsections (d)(1)(A) through (d)(1)(C) and (e)(2) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
 - B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
 - C) The final rate described in subsection (d)(1)(C) of this Section shall be no less than \$147.09 per encounter.
- 3) County-operated outpatient facilities, as described in Section 148.25(b)(2)(C), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (d).
- 4) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to encounter rate hospitals in the same manner as to hospitals

reimbursed under the Ambulatory Care Program and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.

e) Critical Clinic Providers

- 1) Effective for services provided on or after September 27, 1997, a clinic owned or operated by a county with a population of over three million, that is within or adjacent to a hospital, shall qualify as a Critical Clinic Provider if the facility meets the efficiency standards established by the Department. The Department's efficiency standards under this subsection (e) require that the quotient of total encounters per facility fiscal year for the Critical Clinic Provider divided by total full time equivalent physicians providing services at the Critical Clinic Provider shall be greater than:
 - A) 2700 for reimbursement provided during the facility's cost reporting year ending during 1998,
 - B) 2900 for reimbursement provided during the facility's cost reporting year ending during 1999,
 - C) 3100 for reimbursement provided during the facility's cost reporting year ending during 2000,
 - D) 3600 for reimbursement provided during the facility's cost reporting year ending during 2001, and
 - E) 4200 for reimbursement provided during the facility's cost reporting year ending during 2002.
- 2) Reimbursement for all services provided by any Critical Clinic Provider shall be on an all-inclusive per-encounter rate which shall equal reported direct costs of Critical Clinic Providers for each facility's cost reporting period ending in 1995, and available to the Department as of September 1, 1997, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.
- 3) Critical Clinic Providers, as described in this subsection (e), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (e).

- 4) The reimbursement rates described in this subsection (e) shall be no less than the reimbursement rates in effect on July 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- f) **Critical Clinic Provider Pharmacies**
Prescribed drugs, dispensed by a pharmacy that is a Critical Clinic Provider, that are not part of an encounter reimbursable under subsection (e) of this Section shall be reimbursed at the rate described in subsection (e)(2) of this Section.

(Source: Amended at 30 Ill. Reg. 10393, effective May 26, 2006)

Section 148.150 Public Law 103-66 Requirements

- a) All hospitals deemed eligible to receive disproportionate share hospital (DSH) adjustment payments, in accordance with Section 148.120, are required, and non-DSH cost reporting hospitals are encouraged, to annually submit, on or before August 15 of the rate year, at least the following information separated by inpatient and outpatient (including hospital-based clinic services) to the Department:
 - 1) The dollar amount of Illinois Medicaid charges rendered in the base year.
 - 2) The dollar amount of hospital charity care charges rendered in the base year for uninsured patients.
 - 3) The dollar amount of hospital bad debt, less any recoveries, rendered in the base year for uninsured patients.
 - 4) The dollar amount of Illinois total hospital charges for care rendered in the base year.
- b) Definitions
 - 1) "Medicaid charges" means hospital charges for inpatient, outpatient and hospital-based clinic services provided to recipients of medical assistance under Title XIX of the Social Security Act.
 - 2) "Total charges" means the total amount of a hospital's charges for inpatient, outpatient and hospital-based clinic services it has provided.
 - 3) "Base year" means the hospital's cost reporting period, utilized in the current rate year disproportionate share determination, and as described in Section 148.120(k)(1).
 - 4) "Hospital charity care charges" and "hospital bad debt" mean inpatient, outpatient and hospital clinic services provided to individuals without health insurance or other sources of third party coverage. For purposes of the previous statement in this subsection (b)(4), State or unit of local government payments made to a hospital on behalf of indigent patients (i.e., Transitional Assistance and State Family and Children Assistance) shall not be considered to be a form of insurance or a source of third party coverage. Therefore, unreimbursed charges for persons covered under these programs may be included. Charity care charges and bad debt

cannot include unpaid co-pays or third party obligations of insured patients, contractual allowances, or the hospital's charges or reduced charges attributable to services provided under its obligation pursuant to the federal Hill-Burton Act (42 USC 291).

(Source: Amended at 28 Ill. Reg. 9661, effective July 1, 2004)

Section 148.160 Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three Million

a) Reimbursement Methodology

In accordance with 89 Ill. Adm. Code 149.50 (c)(8), county-owned hospitals in an Illinois county with a population greater than three million are excluded from the DRG PPS and are reimbursed in accordance with this Section.

b) Base Year Costs

- 1) The hospitals' base year operating costs shall be contained in the hospitals' audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospitals fiscal years ending between 20 and 31 months prior to the fiscal year for which rates are being set.
- 2) The hospitals' base year capital related costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) of this Section.
- 3) The hospitals' base year direct medical education costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) of this Section.
- 4) The base year cost per diem shall be the sum of the operating cost per diem, capital related cost per diem and medical education cost per diem defined in subsections (b)(1) through (b)(3) of this Section.
- 5) New hospitals, for which a base year cost report is not on file, will be reimbursed the per diem rate calculated in subsection (b)(4) of this Section and inflated in subsection (d)(1) of this Section.

c) Restructuring Adjustments

Adjustments to the base year cost per diem, as described in subsection (b)(4) of this Section, will be made to reflect restructuring since filing the base year cost reports. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost reports to determine restructuring costs. If

audited cost reports become available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Illinois Department of Public Aid, Office of Health Finance, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Office of Health Finance, between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the reports are received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies, and added to the base year cost per diem, as described in subsection (b)(4) of this Section, which is subject to the inflation adjustment described in subsection (d) of this Section.

- d) Inflation Adjustment For Base Year Cost Report Inflator
 - 1) The base year cost per diem, as defined in subsection (b)(4) of this Section, shall be inflated from the midpoint of the hospitals' base year to the midpoint of the time period for which rates are being set (rate period) according to the historical rate of annual cost increases. The historical rate of annual cost increases shall be calculated by dividing the operating cost per diem as defined in subsection (b)(1) of this Section by the previous year's operating cost per diem.
 - 2) Effective October 1, 1992, the final reimbursement rate shall be no less than the reimbursement rate in effect on June 1, 1992; except that this minimum shall be adjusted each July 1 thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports.
 - 3) Effective July 1, 2003, the rate for hospital inpatient services shall be the rate calculated in accordance with subsections (d)(1) and (2) of this Section that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.
- e) Review Procedure

The review procedure shall be in accordance with Section 148.310.
- f) Applicable Inpatient Adjustments

- 1) The criteria and methodology for making applicable adjustments to DSH hospitals, which are exempt from the DRG PPS, as described in subsection (a) of this Section, shall be in accordance with Section 148.120.
- 2) The criteria and methodology for making applicable Medicaid Percentage Adjustments to hospitals which are exempt from the DRG PPS as described in subsection (a) of this Section are described in this Section.
 - A) The payment adjustment shall be \$150 plus \$2 for each one percent that the hospital's Medicaid inpatient utilization rate, as described in Section 148.120(k)(5), exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(3), multiplied by 3.75. This payment adjustment is based on a rate year 1993 base rate and shall be trended forward to the current rate year for inflationary increases.
 - B) The amount calculated pursuant to subsection (f)(2)(A) of this Section shall be adjusted on October 1, 1995, and annually thereafter, by a percentage equal to the lesser of:
 - i) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or
 - ii) The percentage increase in the statewide average hospital payment rate, as described in Section 148.120(k)(8) over the previous year's statewide average hospital payment rate.
 - C) The amount calculated pursuant to subsections (f)(2)(A) through (f)(2)(B) of this Section shall be no less than the rate calculated in accordance with Section 148.120(g)(2) in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
 - D) Effective July 1, 2003, the Medicaid Percentage Adjustment rate for hospital inpatient services shall be the rate that was in effect on

January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.

- E) The amount calculated pursuant to subsection (f)(2) of this Section shall be the Medicaid percentage adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

3) County Provider Adjustment.

- A) Effective July 1, 1995, hospitals reimbursed under this Section shall be eligible to receive a county provider adjustment. The methodology used to determine the add-on payment amount is as follows:

- i) Beginning with July 1, 1995, hospitals under this Section shall receive \$15,500 per Medicaid inpatient admission in the base period.
- ii) The payments calculated under this Section may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. A portion of the payments calculated under this Section may be classified as disproportionate share adjustment payments.
- iii) The payments made under this subsection shall be made on a quarterly basis.

B) County Provider Adjustment Definitions.

- i) "Base Period" means State fiscal year 1994.
- ii) "Medicaid Inpatient Admission" means hospital inpatient admissions provided in the base period, which were subsequently adjudicated by the Department through the last day of June, 1995, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns and Medicare/Medicaid crossover days.

- 4) Hospitals reimbursed under this Section shall receive supplemental inpatient payments. Effective with admissions on or after July 1, 1995, supplemental inpatient payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in subsection (b)(4) of this Section, as adjusted for restructuring, as described in subsection (c) of this Section, and as adjusted for inflation, as described in subsection (d) of this Section, and the sum of the calculated disproportionate share and Medicaid percentage per diem payments as described in Section 148.120 and subsection (f)(2) of this Section, by the hospitals' percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. Effective July 1, 1995, the supplemental inpatient payments calculated under this subsection shall be no less than the supplemental inpatient rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid cost by the total allowable Medicaid days. Effective July 1, 2003, the supplemental inpatient payment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. The supplemental inpatient payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.
- g) **Outlier Adjustments**
Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.
- h) **Trauma Center Adjustments.** Trauma center adjustments shall be made in accordance with Section 148.290(c).
- i) **Reductions to Total Payments**
 - 1) **Copayments.** Copayments are assessed in accordance with Section 148.190.

- 2) Third Party Payments. The requirements of Section 148.290(f)(2) shall apply.
- j) Prepayment and Utilization Review
Prepayment and utilization review requirements shall be in accordance with Section 148.240.
- k) Cost Reporting Requirements
Cost reporting requirements shall be in accordance with Section 148.210.

(Source: Amended at 28 Ill. Reg. 2770, effective February 1, 2004)

Section 148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act

- a) In accordance with 89 Ill. Adm. Code 149.50(c)(8), a hospital organized under the University of Illinois Hospital Act shall be excluded from the DRG PPS and shall be reimbursed in accordance with this Section.
- b) Base Year Costs
 - 1) Each hospital's base year cost per diem shall be derived from an audited cost report (see 42 CFR 447.260 and 447.265 (1982)) for hospitals' fiscal year 1992.
 - 2) For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.
- c) Restructuring Adjustment

Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Illinois Department of Public Aid, Office of Health Finance, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Finance Section between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the report is received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the

restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year costs.

- d) **Inflation Adjustment For Base Year Cost Report Inflator**
Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set according to the hospital's historical rate of annual cost increases.
- e) **Review Procedure**
The review procedure shall be in accordance with Section 148.310.
- f) **Applicable adjustments for DSH Hospitals**
 - 1) The criteria and methodology for making applicable adjustments to DSH hospitals, which are exempt from the DRG PPS as described in subsection (a) of this Section, shall be in accordance with Section 148.120.
 - 2) Effective October 1, 1993, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall have supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's base year costs, as described in subsection (b) of this Section, as adjusted for restructuring, as described in subsection (c) of this Section, and as adjusted for inflation, as described in subsection (d) of this Section, and the calculated disproportionate share per diem payment adjustment, as described in Section 148.120, by the hospital's percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. The resulting product shall be multiplied by 4.50 and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.
- g) **Outlier Adjustments**
Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.
- h) **Reductions to Total Payments**

- 1) Copayments. Copayments are assessed in accordance with Section 148.190.
- 2) Third Party Payments. The requirements of Section 148.290(f)(2) shall apply.
- i) Prepayment and Utilization Review
Prepayment and utilization review requirements shall be in accordance with Section 148.240.
- j) Cost Reporting Requirements
Cost reporting requirements shall be in accordance with Section 148.210.
- k) Rate Period

The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year, except for the period of July 1, 1995, through September 30, 1995.

(Source: Amended at 28 Ill. Reg. 2770, effective February 1, 2004)

Section 148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act

- a) The Department shall make supplemental disproportionate share (DSH) payments in accordance with this Section to hospitals that meet all of the following requirements:
 - 1) Qualify for DSH payment adjustments in accordance with Section 148.120(a).
 - 2) Are organized under the Town Hospital Act [60 ILCS 170].
 - 3) Have entered into an agreement, approved by the Director.
- b) Review Procedure
The review procedure shall be in accordance with Section 148.310.
- c) Applicable Adjustments for Disproportionate Share Hospitals (DSH)
 - 1) The criteria and methodology for making applicable adjustments to government owned DSH hospitals as described in subsection (a) above, shall be in accordance with Section 148.120.
 - 2) Effective with dates of service on or after May 12, 1995, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall be eligible for supplemental DSH payments. Effective with admissions on or after May 12, 1995, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's alternate cost per diem rate in effect on May 12, 1995, as described in Sections 148.260, 148.270 and 89 Ill. Adm. Code 152.200, and the calculated disproportionate share per diem payment adjustment in effect on May 12, 1995, as described in Section 148.120, by the hospital's percentage of charges which are not reimbursed by a third party payor for the period of August 1, 1991 through July 31, 1992. The resulting product shall be multiplied by 6.25 and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided. The supplemental DSH payments cannot exceed the amount the hospital certifies as costs eligible for Federal Financial Participation under Title XIX of the Social Security Act.
 - 3) DSH adjustments made under this subsection are subject to the DSH adjustment limitations described in Section 148.120(j).
- d) Rate Period
The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year, except for the period of May 12, 1995 through September 30, 1995.

(Source: Added at 19 Ill. Reg. 13009, effective September 5, 1995)

Section 148.180 Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting

- a) Pre-Operative Days. For hospitals and distinct part units reimbursed on a per diem basis under Sections 148.160, 148.170 or 148.250 through 148.300, payment for pre-operative days shall be limited to the day immediately preceding surgery unless the attending physician has documented the medical necessity of an additional day or days. The documentation must be kept in the patient's medical record and must consist of a written notation made by the physician which documents that more than one pre-operative day is medically necessary.
- b) Inpatient Procedures Requiring Justification
 - 1) A list of restricted inpatient procedures has been established. These restricted inpatient procedures will only be reimbursed when performed outside the inpatient setting or when the hospital supplies justification for an inpatient admission that meets Departmental established criteria. These criteria include, but are not limited to:
 - A) Presence of medical conditions which make prolonged post-operative observations by a nurse or skilled medical personnel a necessity (e.g., heart disease, severe diabetes);
 - B) The patient is in the hospital as an inpatient for a medically necessary condition unrelated to the surgical procedure;
 - C) An unrelated procedure is being done simultaneously which itself requires surgical hospitalization;
 - D) The practitioner has documented the medical necessity of performing the patient's surgery in an inpatient setting;
 - E) The patient is unable to comprehend and/or follow the necessary instruction both prior to and following the procedure due to mental and/or physical impairment, and this would result in inadequate treatment and place the patient at risk;
 - F) Emergency admission or recent onset of severe symptoms would prohibit safely performing the procedure on an outpatient basis (e.g., bleeding, severe pain, nausea, vomiting); and
 - G) Admission occurs subsequent to the performance of the procedure on an outpatient basis due to conditions such as:
 - i) Instability of vital signs;
 - ii) Respiratory distress greater than existed pre-operatively;
 - iii) Post-operative pain not relieved by oral medication;
 - iv) Uncontrolled bleeding;
 - v) Lack of state of consciousness appropriate to age and development;
 - vi) Presence of persistent nausea or vomiting; and

- vii) Inability to ambulate consistent with age, previous mobility status and/or procedure.
 - 2) The list of procedures identified as restricted inpatient procedures which may be safely performed outside the inpatient setting and do not require an inpatient admission are reevaluated periodically.
 - 3) Additions to and deletions from the list of designated restricted inpatient procedures will be made following notice to and consultations with the Department's professional advisory committees, State Medicaid Advisory Committee, representatives selected by the hospitals, other third party payors, the Illinois Hospital Association, and other interested groups or individuals.
- c) Ancillary Services and Tests
- 1) Ancillary services and routine tests (those services other than routine room and board and nursing which are required because of the patient's medical condition, including lab tests and x-rays) shall not be covered unless there is a patient specific written order for the test from the attending or operating physician responsible for the care and treatment of the patient. The attending or operating physician responsible for the care and treatment of the patient is required to sign all applicable sections for each test ordered in the appropriate place in the medical record. The order must be legible and explain completely all services or tests to be performed. Standing orders are not acceptable.
 - 2) Upon completion of the service or test, a fully documented description of results with findings, or the administration of medication, must be maintained in the patient medical records. Radiological services must have the actual x-rays and the interpretation report; laboratory/pathological tests must have the specific findings for each test; and drugs and pharmaceutical supplies must indicate strength, dosages and durations.
 - 3) Charges for any and all such services or tests cannot exceed those charged to the general public. The failure to maintain and provide records as described in this Section shall result in the disallowance of the applicable charges upon audit.

(Source: Amended at 18 Ill. Reg. 3450, effective February 28, 1994)

Section 148.190 Copayments

- a) With the exception of those classes of individuals identified in 89 Ill. Adm. Code 140.402(d), copayments will be assessed on inpatient services provided under all Medical Assistance Programs administered by the Department. Copayments will be in the following amounts:
 - 1) Inpatient hospital services in hospitals with an alternate cost per diem rate (see Section 148.270(a)) of \$325 or more \$3 per day.
 - 2) Inpatient hospital services in hospitals with an alternate cost per diem rate (see Section 148.270(a)) of more than \$275 but less than \$325 \$2 per day.
 - 3) Inpatient hospital services in hospitals with an alternate cost per diem rate (see Section 148.270(a)) of \$275 or less No Copayment.
- b) In each instance where a copayment is payable, the Department will reduce the amount payable to the affected provider by the amount of the required copayment.
- c) No provider may deny care or services on account of an individual's inability to pay a copayment; this requirement, however, shall not extinguish the liability for payment of the copayment by the individual to whom the care or services were furnished.

(Source: Amended at 28 Ill. Reg. 2770, effective February 1, 2004)

Section 148.200 Alternate Reimbursement Systems

- a) Section 148.210 discusses cost reporting requirements for all hospitals participating in the Medicaid Program.
- b) Section 148.220 describes the payment methodology for hospital inpatient services to recipients for admissions occurring prior to September 1, 1991.
- c) The payments described in Sections 148.250 through 148.300 shall be effective for admissions on and after October 1, 1992, subject to the provisions of Section 148.20(b).
- d) The payments described in Section 148.82 shall be effective for admissions on and after September 1, 1991, with the exception of provisions that relate to pancreas or kidney-pancreas transplants. Provisions relating to pancreas or kidney-pancreas transplants shall be effective for admissions on and after July 1, 1992.
- e) Sections 148.250 through 148.300 describe the payment methodologies for hospital inpatient services to recipients of Medical Assistance provided by a hospital not reimbursed under the DRG Prospective Payment System (PPS) described in 89 Ill. Adm. Code 149 or the reimbursement methodologies described in Sections 148.82, 148.160 and 148.170.

(Source: Amended at 18 Ill. Reg. 3450, effective February 28, 1994)

Section 148.210 Filing Cost Reports

- a) All hospitals in Illinois, those hospitals in contiguous states providing 100 or more paid acute inpatient days of care to Illinois Medicaid Program participants, and all hospitals located in states contiguous to Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)), shall be required to file Medicaid and Medicare cost reports within 150 days after the close of that provider's fiscal year.
 - 1) Any hospital certified in the Medicare Program (Title XVIII) and electing, for the first time, to be reimbursed under the DRG PPS must include a copy of the two most recently audited Medicare cost reports at the time of enrollment.
 - 2) Any hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) not eligible for or subject to Medicare certification shall be required to file financial statements, a statement of revenues and expenses by program, and census logs by program and financial class. The Office of Health Finance may request an audit of the financial statements by an independent Certified Public Accountant (CPA) firm if the financial statements are to be used as the base year for rate analysis. Should the hospital elect not to comply with the audit request, or the financial statements are given other than an unqualified opinion, the hospital will receive an alternate rate as described in Section 148.270.
- b) No extension of the Medicaid cost report due date will be granted by the Department unless the Centers for Medicare and Medicaid Services (CMS) grants an extension of the due date for the Medicare cost report. Should CMS extend the Medicare cost report due date, the Department will extend the Medicaid and Medicare cost reports due date by an equivalent period of time.
- c) If the hospital has not filed the required Medicaid cost reports within 150 days after the close of the hospital's fiscal year, the Department shall suspend payment for covered medical services until the Department receives the required information.
- d) The assessment or license fees described in 89 Ill. Adm. Code 140.80, 140.82, 140.84, 140.94 and 140.95, may not be reported as allowable Medicaid costs on the Medicaid cost report.

(Source: Amended at 28 Ill. Reg. 8072, effective June 1, 2004)

Section 148.220 Pre September 1, 1991, Admissions

Reimbursement to hospitals for claims for admissions occurring prior to September 1, 1991, will be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered.

(Source: Amended at 17 Ill. Reg. 3296, effective March 1, 1993)

Section 148.230 Admissions Occurring on or after September 1, 1991

Reimbursement to hospitals not reimbursed under the DRG PPS (see 89 Ill. Adm. Code 149) or the reimbursement methodologies established at Sections 148.82, 148.160 and 148.170 for inpatient admissions occurring on or after September 1, 1991, shall be calculated in accordance with Sections 148.250 through 148.300, subject to the provisions of Section 148.20(b).

(Source: Amended at 18 Ill. Reg. 3450, effective February 28, 1994)

Section 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements

a) Utilization Review

The Department, or its designated peer review organization, shall conduct utilization review in compliance with Section 1152 of the Social Security Act and 42 CFR Subchapter F (October 1, 2001). A peer review shall be conducted by a Physician Peer Reviewer who is licensed to practice medicine in all its branches, engaged in the active practice of medicine, board certified or board eligible in his or her specialty and has admitting privileges in one or more Illinois hospitals. Payment will only be made for those admissions and days approved by the Department or its designated peer review organization. Utilization review may consist of, but not be limited to, preadmission, concurrent, prepayment, and postpayment reviews to determine, pursuant to 42 CFR 476, Subpart C (October 1, 2001), the following:

- 1) Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury;
- 2) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges, including, but not limited to, the coordination of care requirements defined in Section 148.40(a)(10) for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program;
- 3) Through DRG (Diagnosis Related Grouping) (see 89 Ill. Adm. Code 149) validation, the validity of diagnostic and procedural information supplied by the hospital;
- 4) The completeness, adequacy and quality of hospital care provided;
- 5) Whether the quality of the services meets professionally recognized standards of health care; or
- 6) Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient health care facility of a different type.

b) Notice of Utilization Review

The Department shall provide hospitals with notice 30 days before a service is subject to utilization review, as described in subsections (c), (d), (e) and (f) of this

Section, that the service is subject to such review. In determining whether a particular service is subject to utilization review, the Department may consider factors that include:

- 1) Assessment of appropriate level of care;
 - 2) The service could be furnished more economically on an outpatient basis;
 - 3) The inpatient hospital stays for the service deviate from the norm for inpatient stays using accepted length of stay criteria;
 - 4) The cost of care for the service;
 - 5) Denial rates; and
 - 6) Trends or patterns that indicate potential for abuse.
- c) **Preadmission Review**
Preadmission review may be conducted prior to admission to a hospital to determine if the services are appropriate for an inpatient setting. The Department shall provide hospitals with notice of the criteria used to determine medical necessity in preadmission reviews 30 days before a service is subject to preadmission review.
- d) **Concurrent Review**
Concurrent review consists of a certification of admission and, if applicable, a continued stay review.
- 1) The certification of admission is performed to determine the medical necessity of the admission and to assign an initial length of stay based on the criteria for the admission.
 - 2) The continued stay review is conducted to determine the medical necessity and appropriateness of continuing the inpatient hospitalization. More than one continued stay review can be performed in an inpatient stay.
- e) **Prepayment Review**
The Department may require hospitals to submit claims to the Department for prepayment review and approval prior to rendering payment for services provided.
- f) **Postpayment Review**

Postpayment review shall be conducted on a random sample of hospital stays following reimbursement to the hospital for the care provided. The Department may also conduct postpayment review on specific types of care.

g) Hospital Utilization Control

Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456 (October 1, 2001). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50(c)(1) shall be in accordance with the federal regulations.

h) Denial of Payment as a Result of Utilization Review

- 1) If the Department determines, as a result of utilization review, that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:
 - A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission, transfer of an individual or failure to comply with the coordination of care requirements of Section 148.40.
 - B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.
- 2) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization, under subsection (h)(1)(A) of this Section as a result of prepayment review, a reconsideration will be provided within 30 days upon the request of a hospital or physician if such request is the result of a medical necessity or appropriateness of care denial determination and is received within 60 days after receipt of the notice of denial. The date of the notice of denial is counted as day one.

- 3) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization under subsection (h)(1)(A) of this Section as a result of a preadmission or concurrent review, the hospital or physician may request an expedited reconsideration. The request for expedited reconsideration must include all the information, including the medical record, needed for the Department or its designated peer review organization to make its determination. A determination on an expedited reconsideration request shall be completed within one business day after the Department's or its designated peer review organization's receipt of the request. Failure of the hospital or physician to submit all needed information shall toll the time in which the reconsideration shall be completed. The results of the expedited reconsideration shall be communicated to the hospital by telephone within one business day and in writing within three business days after the determination.
- 4) A determination under subsection (h)(1) of this Section, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in:
 - A) withholding Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
 - B) termination of the hospital's Provider Agreement.
- i) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements
 - 1) The applicable payments made under Sections 148.82, 148.120, 148.130, 148.150, 148.160, 148.170, 148.175 and 148.250 through 148.300 are payment in full for all inpatient hospital services other than for the services of nonhospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (i)(1)(B)(i) through (i)(1)(B)(v) of this Section.
 - A) Hospital-based physicians who may not bill separately on a fee-for-service basis:
 - i) A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.

- ii) A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.
- B) Hospital-based physicians who may bill separately on a fee-for-service basis:
 - i) A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.
 - ii) A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.
 - iii) A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.
 - iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.
 - v) A physician holding a nonteaching administrative or staff position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.
- 2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the

operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

- j) “Designated peer review organization” means an organization designated by the Department that is experienced in utilization review and quality assurance, which meets the guidelines in Section 1152 of the Social Security Act and 42 CFR 475 (October 1, 2001).

(Source: Amended at 28 Ill. Reg. 15536, effective November 24, 2004)

Section 148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals

The exempt hospitals, defined in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), (c)(4) and (c)(7), shall be reimbursed for inpatient hospital care provided to recipients by summing the following reimbursement calculations:

- a) allowable operating cost per diem;
- b) capital costs reimbursed on a per diem basis;
- c) applicable DSH adjustments as described in Section 148.120 and outlier adjustments as described in Section 148.130; and
- d) applicable trauma center adjustments, as described in Section 148.290(c), and Medicaid high volume adjustments, as described in Section 148.290(d).

(Source: Amended at 19 Ill. Reg. 10060, effective June 29, 1995)

Section 148.260 Calculation and Definitions of Inpatient Per Diem Rates

- a) Calculation for the first rate year period
 - 1) Allowable operating cost per diem
 - A) The allowable operating cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking the hospital's Medicaid inpatient operating costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's Medicaid inpatient days.
 - B) Operating cost base per diem rates for hospital inpatient care provided to Medicaid recipients beginning September 1, 1991, shall be calculated by:
 - i) Calculating each individual hospital's cost per diem less capital and direct medical education costs for each of the two most recent years for which an audited Medicaid cost report exists, as described in subsection (a)(1)(A) above.
 - ii) Each of the two costs per diem shall be trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).
 - iii) These two trended operating costs per diem are then added together and divided by two.
 - iv) The average operating cost per diem calculated in subsection (a)(1)(B)(iii) above is then divided by the indirect medical education (IME) factor, determined by the Health Care Financing Administration (HCFA), in effect 90 days prior to the admission in order to calculate the hospitals final operating cost per diem for the base period. For other hospitals for which an indirect medical education factor is not available, the Department shall calculate an indirect medical education factor using the hospital's most recently available cost report and the Medicare formula in effect 90 days prior to the date of admission.
 - 2) Capital Related Costs. The capital related cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking the hospital's total capital related costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).

- A) These two trended capital related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.
 - B) The adjusted capital related cost per diem, as calculated in subsection (a)(2)(A) above, shall be rank ordered for all hospitals and capped at the 80th percentile.
 - C) Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (a)(2)(A) or subsection (a)(2)(B) above, whichever is less.
- 3) Direct Medical Education Costs. The direct medical education cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking total inpatient direct medical education costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).
 - A) The two trended direct medical education cost per diems are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.
 - B) The adjusted direct medical education cost per diem, as calculated in subsection (a)(3)(A) above, shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.
 - C) Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in subsection (a)(3)(A) or subsection (a)(3)(B) above, whichever is less.
- b) Calculation for Subsequent Rate Periods
 - 1) For the rate period described in Section 148.25(g)(2)(A), the final rate per diem shall be determined by taking the operating, capital and direct medical education trended rate cost per diems calculated under subsection (a) of this Section and updating those costs by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(A).
 - 2) For rate periods beginning on or after April 1, 1994, as described in Section 148.25(g)(2)(B), the final rate per diem shall be determined by:
 - A) Adding the operating and capital trended rate cost per diems calculated under subsection (a) of this Section that were in effect on June 30, 1993;
 - B) Updating the trended rate cost per diems described in subsection (b)(2)(A) above:
 - i) In the case of a hospital described in 89 Ill. Adm. Code 149.125(b), by the national hospital market basket price

- proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(B); and
- ii) In the case of a hospital described in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), or (c)(4), or for a hospital unit described in 89 Ill. Adm. Code 149.50(d)(1) or (d)(2), to the midpoint of the current rate period described in Section 148.25(g)(2)(B) by utilizing the TEFRA price inflation factor.
- c) **Rebasing**
For the rate period beginning after October 1, 1994, and every third rate period thereafter, the final rate per diem shall be calculated using the methodology set forth in subsection (a) of this Section for the calculation of operating and capital trended rate cost per diems using base period cost reports, as described in Section 148.25(g)(1).

(Source: Amended at 19 Ill. Reg. 10060, effective June 29, 1995)

Section 148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals

- a) Calculation of Alternate Cost Per Diem Rates for All Hospitals
For all hospitals, regardless of the hospital's reimbursement methodology, the Department shall first calculate the hospital's alternate cost per diem rate, as calculated under Section 148.260, derived from the provider's base period cost reports, as described in Section 148.25(g)(1).
- b) Calculation of Payment Rates for Certain Exempt Hospital Units
 - 1) For admissions occurring within the rate period described in Section 148.25(g)(2)(A):
 - A) In the case of a distinct part unit, as described in 89 Ill. Adm. Code 149.50(d), the Department shall divide the hospital's Medicaid charges per diem (identified on adjudicated claims submitted by the provider during the most recently completed fiscal year for which complete data are available) related to the distinct part unit by the hospital's total charge per diem for all claims for the same time period.
 - B) The resulting quotient, as calculated in subsection (b)(1)(A) above, shall be multiplied by the hospital's total operating cost per diem, as calculated in Section 148.260(a)(1)(B).
 - C) The capital related cost per diem, as calculated in Section 148.260(a)(2), is then added to the resulting product calculated in subsection (b)(1)(B) above, subject to the inflation adjustment described in Section 148.260(c)(1).
 - D) Subject to the provisions of subsections (b)(1)(E) and (b)(1)(F) below, the final distinct part unit payment rate shall be the lower of:
 - i) The result of the calculations described in subsections (b)(1)(A) through (b)(1)(B) above; or
 - ii) The hospital's alternate cost per diem rate, as calculated in subsection (a) above.
 - E) In no case shall the hospital's final distinct part unit payment rate be greater than three standard deviations above the mean distinct part unit payment rate.
 - F) In the case of a new distinct part unit for which the Department has insufficient adjudicated claims history data available, the Department shall utilize the average payment rate calculated under this subsection (b)(1) for like distinct part units.
 - 2) For admissions occurring within a rate period described in Section 148.25(g)(2)(B), the distinct part unit payment rate shall be the distinct

part unit payment rate in effect on June 30, 1993, as calculated under subsection (b)(1) above, updated to the midpoint of the current rate period, using the TEFRA price inflation factor.

- c) In the case of a new hospital (not previously owned or operated), a hospital that has significantly changed its case-mix profile (e.g. a general acute care hospital changing its case-mix to reflect a predominance of long term care patients), or an out-of-state non cost-reporting hospital, reimbursement for inpatient services shall be as follows:
- 1) For general acute-care hospitals, reimbursement for inpatient services shall be at the average payment rate calculated under subsection (a) or (b) above, as applicable, for those hospitals reimbursed under 89 Ill. Adm. Code 149.
 - 2) For psychiatric hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(1), reimbursement for inpatient psychiatric services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(1).
 - 3) For rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), reimbursement for inpatient rehabilitation services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(2).
 - 4) For long term stay hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(4), reimbursement for inpatient services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(4).
 - 5) For children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), reimbursement for inpatient services:
 - A) provided before August 1, 1998, shall be at the average rate calculated under subsection (a) above for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(3);
 - B) provided on or after August 1, 1998, for a children's hospital that was licensed as such by a municipality after June 30, 1995, shall be equal to the average rate calculated in Section 148.280 for children's hospitals in existence before June 30, 1995, with an average length of stay that was less than 14 days as determined from the hospital's fiscal year 1994 cost report.

(Source: Amended at 22 Ill. Reg. 21490, effective November 25, 1998)

Section 148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements

- a) Children's Hospitals
 - 1) Initial Rate Period
 - A) For purposes of reimbursement, all children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), are grouped into one peer group.
 - B) Each hospital's costs for the base period shall be derived from audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospital fiscal years ending during calendar year 1989.
 - C) These base period costs shall be updated, trended forward, from the midpoint of each hospital's base period to the midpoint of the rate period for which rates are being set according to the methodology of the national total hospital market basket price proxies, (DRI).
 - D) The children's hospitals' base period trended rates shall be used as the basis for calculating the group's median trended rate. Each individual hospital's trended rate is then compared to the group's median trended rate. Hospitals whose individual trended rates are higher than the median rates shall receive as a final inpatient payment rate their trended rate minus half the difference between their trended rate and the group's median trended rate. Hospitals whose trended rates are lower than the group's median trended rate shall receive as its final inpatient payment rate their individual trended rate plus half the difference between their trended rate and the group's median trended rate.
 - 2) Subsequent Rate Periods

For the rate period beginning on October 1, 1992, as described in Section 148.25(g)(1)(A), and for subsequent rate periods, as described in Section 148.25(g)(1)(B), the initial rate, as calculated under subsection (a)(1) above, shall be updated from the midpoint of the base cost reporting period to the midpoint of the rate period using the national hospital market basket price proxies (DRI).
- b) Hospitals Reimbursed Under Special Arrangements

Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in Sections 148.40(e) through 148.40(g).

(Source: Amended at 18 Ill. Reg. 3450, effective February 28, 1994)

Section 148.285 Excellence in Academic Medicine Payments

Payments for Qualified Academic Medical Center Hospitals providing graduate medical education shall be made for inpatient admissions occurring on or after July 1, 1996, and for Independent Academic Medical Center Hospitals providing graduate medical education shall be made for inpatient admissions occurring on or after July 1, 2001, as follows:

- a) Subject to the availability of funds from the accounts within the Medical Research and Development Fund, including any federal financial participation reimbursed for payments under this subsection (a), payments shall be made to hospitals under the following criteria:
 - 1) Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive a percentage of the amount available from the National Institutes of Health Account equal to that hospital's percentage of the total contracts and grants from the National Institutes of Health awarded to Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospitals and their affiliated medical schools during the preceding calendar year as reported to the Department.
 - 2) Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive payment from the Philanthropic Medical Research Account equal to 25 percent of all funded grants (other than grants funded by the State of Illinois or the National Institutes of Health) for biomedical research, technology, or programmatic development received by the Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital during the preceding calendar year as reported to the Department.
 - 3) Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive payment from the Market Medical Research Account equal to 20 percent of the funding for the project, if, based upon submission of information to the Department, the hospital:
 - A) contributes 40 percent of the funding, that is at least \$100,000, for a biomedical research or technology project or a programmatic development project, and
 - B) obtains contributions from the private sector equal to 40 percent of the funding for the project.
- b) No hospital receiving payments from the Medical Research and Development Fund shall receive more than 20 percent of the total amount appropriated to the Fund, except that total payments from the fund to the primary teaching hospitals affiliated with the Southern Illinois University School of Medicine in Springfield, considered as a single entity, may not exceed the product of:
 - 1) One-sixth of the total amount available for distribution from the Medical Research and Development Fund, and

- 2) The quotient of the National Institutes of Health grants or contracts awarded to the Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals in the previous calendar year divided by \$8,000,000.
- c) The Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals located in Springfield, considered as a single entity, shall be deemed to be a Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital for the purposes of calculating subsections (a) and (b) of this Section. Payments under subsections (a) and (b) of this Section made to the Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals located in Springfield shall be made to, and divided equally between, the primary teaching hospitals in Springfield.
- d) Subject to the availability of funds from the Post-Tertiary Clinical Services Fund, including any federal financial participation reimbursed for payments under this subsection (d), payments shall be made to Qualified Academic Medical Center Hospitals for up to three Qualified Programs in any given year as reported to the Department. Qualified Academic Medical Center Hospitals may receive continued funding for previously funded Qualified Programs rather than receive funding for a new program so long as the number of Qualified Programs receiving funding does not exceed three. Each hospital receiving payments under this subsection (d) shall receive an equal percentage of the Post-Tertiary Clinical Services Fund to be used in the funding of Qualified Programs.
- e) Subject to the availability of funds from the Independent Academic Medical Center Fund, including any federal financial participation reimbursed for payments under this subsection (e), payments shall be made to Independent Academic Medical Center Hospitals.
- f) Payments from funds under this Section are made to cover the direct costs associated with providing Medicaid services and shall be made directly to the Qualified Academic Medical Center Hospitals or Independent Academic Medical Center Hospitals due the funds, except any funds due to any primary teaching hospital for the University of Illinois School of Medicine at Rockford and the University of Illinois School of Medicine at Peoria shall be paid to the University of Illinois at Chicago Medical Center, which shall be bound to expend the funds on its affiliated hospitals due the funds.
- g) No Academic Medical Center Hospital shall be eligible for payments from the Medical Research and Development Fund unless the Academic Medical Center Hospital, in connection with its affiliated medical school, received at least \$8,000,000 in the preceding calendar year in grants or contracts from the National Institutes of Health, except that this restriction does not apply to the entity specified in subsection (c) of this Section.
- h) The rate period for payments made under this Section shall be the 12 month period beginning July 1, 1996, for Qualified Academic Medical Center Hospitals,

and July 1, 2001, for Independent Academic Medical Center Hospitals. A qualifying hospital's total annual payments from each fund and account described in this Section shall be divided into four equal payments and be made by the later of:

- 1) the fifteenth working day after July 1, October 1, January 1, and March 1, or
 - 2) the fifteenth working day after the Department's receipt of reporting information required under subsection (j) of this Section.
- i) Payments made under this Section are for inpatient Medicaid services provided in the 12 month period preceding the rate period.
- j) Qualified Academic Medical Center Hospitals initially identified by the Department as qualifying under any payment criteria of this Section must complete and return a survey, developed by the Department, attesting to information required to calculate payments under this Section. The Department will mail the survey at least 21 days prior to its due date. Failure to complete and submit required information by the due dates established by the Department will result in forfeiture of payments under this Section.
- k) If a hospital is eligible for funds from the Independent Academic Medical Center Fund, that hospital shall not receive funds from the Medical Research and Development Fund or the Post-Tertiary Clinical Services Fund. If a hospital receives funds from the Medical Research and Development Fund or the Post-Tertiary Clinical Services Fund, that hospital is ineligible to receive funds from the Independent Academic Medical Center Fund.
- l) Definitions
- As used in this Section, unless the context requires otherwise:
- 1) "Academic Medical Center Hospital" means a hospital located in Illinois which is either under common ownership with the college of medicine of a college or university, or a free-standing hospital in which the majority of the clinical chiefs of service are department chairmen in an affiliated medical school.
 - 2) "Academic Medical Center Children's Hospital" means a children's hospital which is separately incorporated and non-integrated into the Academic Medical Center Hospital, but which is the pediatric partner for an Academic Medical Center Hospital and serves as the primary teaching hospital for pediatrics for its affiliated medical school. Children's hospitals which are separately incorporated, but integrated into the Academic Medical Center Hospital, are considered part of the Academic Medical Center Hospital.
 - 3) "Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means an Academic Medical Center Hospital located in the Chicago Metropolitan Statistical Area.

- 4) "Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means an Academic Medical Center Hospital located outside the Chicago Metropolitan Statistical Area.
- 5) "Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means any Chicago Metropolitan Statistical Area Academic Medical Center Hospital that either directly or in connection with its affiliated medical school receives in excess of \$8,000,000 in grants or contracts from the National Institutes of Health during the calendar year preceding the beginning of the State fiscal year, except for the purposes of subsection (c) of this Section.
- 6) "Qualified Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means the primary teaching hospital of the University of Illinois School of Medicine at Peoria, the primary teaching hospital for the University of Illinois School of Medicine at Rockford and the primary teaching hospitals for Southern Illinois University School of Medicine in Springfield.
- 7) "Qualified Academic Medical Center Hospital" means a Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital, a Qualified Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital, or an Academic Medical Center Children's Hospital.
- 8) "Independent Academic Medical Center Hospital" means the primary teaching hospital for the University of Illinois College of Medicine that is located in Urbana.
- 9) "Qualified Program" includes:
 - A) Thoracic transplantation: heart and lung, in particular,
 - B) Cancer: particularly biologic modifiers of tumor response, and mechanisms of drug resistance in cancer therapy,
 - C) Shock/Burn: development of biological alternatives to skin for grafting in burn injury, and research in mechanisms of shock and tissue injury in severe injury,
 - D) Abdominal transplantation: kidney, liver, pancreas, and development of islet cell and small bowel transplantation technologies,
 - E) Minimally invasive surgery: particularly laparoscopic surgery,
 - F) High performance medical computing: telemedicine and teleradiology,
 - G) Transmyocardial laser revascularization: a laser creates holes in heart muscles to allow new blood flow,
 - H) PET scanning: viewing how organs function (CT and MRI only allow viewing of the structure of an organ),
 - I) Strokes in the African-American community: particularly risk factors for cerebral vascular accident (strokes) in the

- African-American community at much higher risk than the general population,
- J) Neurosurgery: particularly focusing on interventional neuroradiology,
 - K) Comprehensive eye center: including further development in pediatric eye trauma,
 - L) Cancers: particularly melanoma, head and neck,
 - M) Pediatric cancer,
 - N) Invasive pediatric cardiology,
 - O) Pediatric organ transplantation: transplantation of solid organs and marrow and other stem cells, and
 - P) Such other programs as may be identified by the Department and the Qualified Academic Medical Center Hospital, and approved by the Department, for those programs that meet appropriate biomedical research, technology, or programmatic development standards. Programs that meet appropriate biomedical research, technology or programmatic development standards are those programs that help prevent, detect, diagnose, and treat disease and disability in humans by conducting research that seeks to produce new knowledge, developing or refining medical technologies, or creating, strengthening or expanding the clinical programs of academic medical centers. Moreover, such programs meet the purpose of the Excellence in Academic Medicine Act [30 ILCS 775/5]. That is, they stimulate excellence in academic medicine in Illinois for this and future generations, elevate Illinois as a national center for academic medicine and for health care innovation in the United States, and reverse the current health care trade imbalance so Illinois citizens may obtain highest quality post-tertiary care at home in Illinois.

(Source: Amended at 25 Ill. Reg. 16087, effective December 1, 2001)

Section 148.290 Adjustments and Reductions to Total Payments

- a) **Applicable Adjustments for DSH**
The criteria and methodology for making applicable DSH adjustments to hospitals shall be in accordance with Section 148.120.
- b) **Outlier Adjustments**
Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130 for hospitals that are exempt from the DRG PPS (see 89 Ill. Adm. Code 149).
- c) **County Trauma Center Adjustment (TCA).** Illinois hospitals that, on the first day of July preceding the TCA rate period, are recognized as Level I or Level II trauma centers by the Illinois Department of Public Health, shall receive an adjustment that shall be calculated as follows:
 - 1) The available funds from the Trauma Center Fund for each quarter shall be divided by each eligible hospital's (as defined in subsection (c)(4) of this Section) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter.
 - 2) The county trauma center adjustment payments shall not be treated as payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the Public Aid Code.
 - 3) The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis.
 - 4) **Trauma Center Adjustment Limitations.** Hospitals that qualify for trauma center adjustments under this subsection shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by the Illinois Department of Public Health, or the appropriate licensing agency, as a Level I or a Level II trauma center as required for the adjustment described in subsection (c) of this Section. In these instances, the adjustments calculated under this subsection shall be pro-rated, as applicable, based upon the date that such recognition ceased.

- 5) Trauma Center Adjustment Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments required by subsection (c) of this Section are as follows:
- A) "Available funds" means funds which have been deposited into the Trauma Center Fund, which have been distributed to the Department by the State Treasurer, and which have been appropriated by the Illinois General Assembly.
 - B) "Medicaid trauma admission" means those claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under 18 years of age.
 - C) "TCA base period" means State Fiscal Year 1991, for TCA payments calculated for the October 1, 1992 TCA rate period, State Fiscal Year 1992 for TCA payments calculated for the October 1, 1993, TCA rate period, etc.

- D) "TCA rate period" means, beginning October 1, 1992, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.
 - E) "Trauma Center Fund" means the fund created for the purpose of distributing a portion of monies received by county circuit clerks for certain violations of laws or ordinances regulating the movement of traffic to Level I and Level II trauma centers located in the State of Illinois. The Trauma Center Fund shall also consist of all federal matching funds received by the Department as a result of expenditures made by the Department as required by subsection (c)(4) of this Section.
- d) Medicaid High Volume Adjustments (MHVA)
- 1) For inpatient admissions occurring on or after October 1, 2003, the Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals that meet the following criteria:
 - A) eligible to receive the adjustment payments described in Section 148.122 in the MHVA rate period; and
 - B) Not be a county-owned hospital, as described in Section 148.25 (b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25 (b)(1)(B) in the MHVA rate period.
 - 2) Calculation of Medicaid High Volume Adjustments
 - A) Hospitals meeting the criteria specified in subsection (d)(1) of this Section shall receive a MHVA payment adjustment of \$60.
 - B) For children's hospitals, as defined in Section 148.122(a)(5), the payment adjustment calculated under subsection (d)(2)(A) of this Section shall be multiplied by 2.0.
 - C) The amount calculated pursuant to subsections (d)(2)(A) and (d)(2)(B) of this Section shall be adjusted by the aggregate annual increase in the national hospital market price proxies (DRI) hospital cost index (Health-Care Cost Review, published by Global Insight, 24 Hartwell Avenue, Lexington, MA (2003). This incorporation by reference includes no later amendments or

editions.) from the MHVA rate period 1993, as defined in Section 148.290 (d)(4)(B), through the MHVA rate period 2003, and annually thereafter, by a percentage equal to the lesser of:

- i) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or
 - ii) The percentage increase in the statewide average hospital payment rate, as described in subsection (d)(4)(C) of this Section, over the previous year's statewide average hospital payment rate.
 - D) The adjustments calculated under subsections (d)(2)(A) through (d)(2)(C) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.
- 3) Medicaid High Volume Adjustment Limitations. Hospitals that qualify for MHVA adjustments under subsections (d)(2)(A) through (d)(2)(C) of this Section shall not be eligible for such MHVA adjustments if they are no longer recognized or designated by the Department as a Medicaid Percentage Adjustment hospital, as required by subsection (d)(1) of this Section. In this instance, the annual adjustment described in subsections (d)(2)(A) through (d)(2)(C) of this Section shall be pro-rated, as applicable, based upon the date that the hospital was deemed ineligible for Medicaid Percentage Adjustment payments, under Section 148.122, by the Department.
- 4) Medicaid High Volume Adjustment Definitions. The definitions of terms used with reference to calculation of the MHVA adjustments required by subsection (d) of this Section are as follows:
- A) "MHVA base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, MHVA determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, MHVA determination year, etc.
 - B) "MHVA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

- C) "Statewide Average Hospital Payment Rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).
- e) Inpatient Payment Adjustments based upon Reviews. Appeals based upon a hospital's ineligibility for the inpatient payment adjustments described in this Section, or their payment adjustment amounts, in accordance with Section 148.310, which result in a change in a hospital's eligibility for inpatient payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the inpatient payment adjustments of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for inpatient payment adjustments based upon the requirements of this Section.
- f) Reductions to Total Payments
 - 1) Copayments. Copayments are assessed in accordance with Section 148.190.
 - 2) Third Party Payments. Hospitals shall determine that services are not covered, in whole or in part, under any program or under any other private group indemnification or insurance program, health maintenance organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

(Source: Amended at 28 Ill. Reg. 2770, effective February 1, 2004)

**Section 148.295 Critical Hospital Adjustment Payments (CHAP)
EMERGENCY**

Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25 (b)(1)(A), unless otherwise noted in this Section, and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25 (b)(1)(B), for inpatient admissions occurring on or after July 1, 1998, in accordance with this Section.

- a) Trauma Center Adjustments (TCA)
The Department shall make a TCA to Illinois hospitals recognized, as of the first day of July in the CHAP rate period, as a Level I or Level II trauma center by the Illinois Department of Public Health (IDPH) in accordance with the provisions of subsections (a)(1) through (a)(3) of this Section.
 - 1) Level I Trauma Center Adjustment.
 - A) Criteria. Illinois hospitals that, on the first day of July in the CHAP rate period, are recognized as a Level I trauma center by the Illinois Department of Public Health shall receive the Level I trauma center adjustment.
 - B) Adjustment. Illinois hospitals meeting the criteria specified in subsection (a)(1)(A) of this Section shall receive an adjustment as follows:
 - i) Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of \$21,365.00 per Medicaid trauma admission in the CHAP base period.
 - ii) Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of \$14,165.00 per Medicaid trauma admission in the CHAP base period.
 - 2) Level II Rural Trauma Center Adjustment. Illinois rural hospitals, as defined in Section 148.25(g)(3), that, on the first day of July in the CHAP rate period, are recognized as a Level II trauma center by the Illinois

Department of Public Health shall receive an adjustment of \$11,565.00 per Medicaid trauma admission in the CHAP base period.

- 3) Level II Urban Trauma Center Adjustment. Illinois urban hospitals, as described in Section 148.25(g)(4), that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of \$11,565.00 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the criteria described below:

- A) The hospital is located in a county with no Level I trauma center; and
- B) The hospital is located in a Health Professional Shortage Area (HPSA) (42 CFR 5), as of the first day of July in the CHAP rate period, and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (a)(3) of this Section; or the hospital is not located in an HPSA and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (a)(3) of this Section.

b) Rehabilitation Hospital Adjustment (RHA)

Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), and that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following three components:

- 1) Treatment Component. All hospitals defined in subsection (b) of this Section shall receive \$4,215.00 per Medicaid Level I rehabilitation admission in the CHAP base period.
- 2) Facility Component. All hospitals defined in subsection (b) of this Section shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:
 - A) Hospitals with fewer than 60 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of \$229,360.00 in the CHAP rate period.

- B) Hospitals with 60 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of \$527,528.00 in the CHAP rate period.
 - 3) Health Professional Shortage Area Adjustment Component. Hospitals defined in subsection (b) of this Section that are located in an HPSA on July 1, 1999, shall receive \$276.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.
- c) Direct Hospital Adjustment (DHA) Criteria
- 1) Qualifying Criteria

Hospitals may qualify for the DHA under this subsection (c) under the following categories unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006:

 - A) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:
 - i) were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999 and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;
 - ii) were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999 and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or
 - iii) were county owned hospitals as defined in 89 Ill. Adm. Code 148.25(b)(1)(A), and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.
 - B) Illinois hospitals located outside of HSA 6 that had an MIUR greater than 60 percent on July 1, 1999 and an average length of stay less than ten days. The following hospitals are excluded from qualifying under this subsection (c)(1)(B): children's hospitals;

psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.

- C) Children's hospitals, as defined under 89 Ill. Adm. Code 149.50(c)(3), on July 1, 1999.
- D) Illinois teaching hospitals, with more than 40 graduate medical education programs on July 1, 1999, not qualifying in subsection (c)(1)(A), (B), or (C) of this Section.
- E) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsection (c)(1)(A), (B), (C) or (D) of this Section, all other hospitals located in Illinois that had an MIUR equal to or greater than the mean plus one-half standard deviation on July 1, 1999 and provided more than 15,000 Total days.
- F) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A), (B), (C), (D), or (E) of this Section, all other hospitals that had an MIUR greater than 40 percent on July 1, 1999 and provided more than 7,500 Total days and provided obstetrical care as of July 1, 2001.
- G) Illinois teaching hospitals with 25 or more graduate medical education programs on July 1, 1999 that are affiliated with a Regional Alzheimer's Disease Assistance Center as designated by the Alzheimer's Disease Assistance Act [410 ILCS 405/4], that had an MIUR less than 25 percent on July 1, 1999 and provided 75 or more Alzheimer days for patients diagnosed as having the disease.
- H) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(G) of this Section, all other hospitals that had an MIUR greater than 50 percent on July 1, 1999.
- I) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals,

long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(H) of this Section, all other hospitals that had an MIUR greater than 23 percent on July 1, 1999, had an average length of stay less than four days, provided more than 4,200 Total days and provided 100 or more Alzheimer days for patients diagnosed as having the disease.

2) DHA Rates

A) For hospitals qualifying under subsection (c)(1)(A) of this Section, the DHA rates are as follows:

- i) Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive \$69.00 per day for hospitals that do not provide obstetrical care and \$105.00 per day for hospitals that do provide obstetrical care.
- ii) Hospitals that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviation above the Statewide mean Combined MIUR, will receive \$105.00 per day for hospitals that do not provide obstetrical care and \$142.00 per day for hospitals that do provide obstetrical care.
- iii) Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviation above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive \$124.00 per day for hospitals that do not provide obstetrical care and \$160.00 per day for hospitals that do provide obstetrical care.
- iv) Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive \$142.00 per day for hospitals that do not provide obstetrical care and \$179.00 per day for hospitals that do provide obstetrical care.

- B) Hospitals qualifying under subsection (c)(1)(A) of this Section will also receive the following rates:
- i) County owned hospitals as defined in Section 148.25 with more than 30,000 Total days will have their rate increased by \$455.00 per day.
 - ii) Hospitals that are not county owned with more than 30,000 Total days will have their rate increased by \$330.00 per day.
 - iii) Hospitals with more than 80,000 Total days will have their rate increased by an additional \$423.00 per day.
 - iv) Hospitals with more than 4,500 Obstetrical days will have their rate increased by \$101.00 per day.
 - v) Hospitals with more than 5,500 Obstetrical days will have their rate increased by an additional \$194.00 per day.
 - vi) Hospitals with an MIUR greater than 74 percent will have their rate increased by \$147.00 per day.
 - vii) Hospitals with an average length of stay less than 3.9 days will have their rate increased by \$41.00 per day.
 - viii) Hospitals with an MIUR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999 will have their rate increased by \$227.00 per day.
 - ix) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an average length of stay less than four days will have their rate increased by \$528.00 per day.
 - x) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an MIUR greater than 60 percent will have their rate increased by \$320.50 per day.

- xi) Hospitals receiving payments under subsection (c)(2)(A)(iv) of this Section that have an MIUR greater than 70 percent and have more than 20,000 days will have their rate increased by \$98.00 per day.
 - xii) Hospitals with a Combined MIUR greater than 75 percent, that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate increased by \$148.00 per day.
- C) Hospitals qualifying under subsection (c)(1)(B) of this Section will receive the following rates:
 - i) Qualifying hospitals will receive a rate of \$421.00 per day.
 - ii) Qualifying hospitals with more than 1,500 Obstetrical days will have their rate increased by \$369.00 per day.
- D) Hospitals qualifying under subsection (c)(1)(C) of this Section will receive the following rates:
 - i) Hospitals will receive a rate of \$28.00 per day.
 - ii) Hospitals located in Illinois and outside of HSA 6 that have an MIUR greater than 60 percent will have their rate increased by \$55.00 per day.
 - iii) Hospitals located in Illinois and inside HSA 6 that have an MIUR greater than 80 percent will have their rate increased by \$573.00 per day.
 - iv) Hospitals that are not located in Illinois that have an MIUR greater than 45 percent will have their rate increased by \$32.00 per day for hospitals that have fewer than 4,000 Total days; or \$246.00 per day for hospitals that have more than 4,000 Total days but fewer than 8,000 Total days; or \$178.00 per day for hospitals that have more than 8,000 Total days.

- v) Hospitals with more than 3,200 Total admissions will have their rate increased by \$328.00 per day.
- E) Hospitals qualifying under subsection (c)(1)(D) of this Section will receive the following rates:
 - i) Hospitals will receive a rate of \$41.00 per day.
 - ii) Hospitals with an MIUR between 18 percent and 19.75 percent will have their rate increased by an additional \$14.00 per day.
 - iii) Hospitals with an MIUR equal to or greater than 19.75 percent will have their rate increased by an additional \$110.25 per day.
 - iv) Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rate increased by an additional \$41.00 per day.
- F) Hospitals qualifying under subsection (c)(1)(E) of this Section will receive \$188.00 per day.
- G) Hospitals qualifying under subsection (c)(1)(F) of this Section will receive a rate of \$55.00 per day.
- H) Hospitals that qualify under subsection (c)(1)(G) of this Section will receive the following rates:
 - i) Hospitals with an MIUR greater than 19.75 percent will receive a rate of \$69.00 per day.
 - ii) Hospitals with an MIUR equal to or less than 19.75 percent will receive a rate of \$11.00 per day.
- I) Hospitals qualifying under subsection (c)(1)(H) of this Section will receive a rate of \$268.00 per day.
- J) Hospitals qualifying under subsection (c)(1)(I) of this Section will receive a rate of \$238.00 per day.

- K) Hospitals that qualify under subsection (c)(1)(A)(iii) of this Section will have their rates multiplied by a factor of two. The payments calculated under this Section to hospitals that qualify under subsection (c)(1)(A)(iii) of this Section may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. A portion of the payments calculated under this Section may be classified as disproportionate share adjustments for hospitals qualifying under subsection (c)(1)(A)(iii) of this Section.
- 3) DHA Payments
- A) Payments under this subsection (c) will be made at least quarterly, beginning with the quarter ending December 31, 1999.
 - B) Payment rates will be multiplied by the Total days.
 - C) Total Payment Adjustments
 - i) For the CHAP rate period occurring in State fiscal year 2006, total payments will equal the methodologies described in subsection (c)(2) of this Section. For the period January 1, 2006, to June 30, 2006, payment will equal the State fiscal year 2006 amount less the amount the hospital received under DHA for the quarters ending September 30, 2006, and December 31, 2006.
 - ii) For CHAP rate periods occurring after State fiscal year 2006, total payments will equal the methodologies described in subsection (c)(2) of this Section.
- d) Rural Critical Hospital Adjustment Payments (RCHAP)
- RCHAP shall be made to rural hospitals, as described in 89 Ill. Adm. Code 140.80(j)(1), for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive \$367,179.00 per year. The Department shall also make an RCHAP to hospitals qualifying under this subsection at a rate that is the greater of:
- 1) the product of \$1,367.00 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or

- 2) the product of \$138.00 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.
- e) **Total CHAP Adjustments**
Each eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts described in subsections (a), (b), (c) and (d) of this Section. The critical hospital adjustment payments shall be paid at least quarterly.
- f) **Critical Hospital Adjustment Limitations**
Hospitals that qualify for trauma center adjustments under subsection (a) of this Section shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in subsection (a)(1) of this Section, or a Level II trauma center as required for the adjustment described in subsection (a)(2) or (a)(3) of this Section. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased.
- g) **Critical Hospital Adjustment Payment Definitions**
The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:
 - 1) "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates of service occurring in State fiscal year 2001 and adjudicated through June 30, 2002.
 - 2) "CHAP base period" means State Fiscal Year 1994 for CHAP calculated for the July 1, 1995 CHAP rate period; State Fiscal Year 1995 for CHAP calculated for the July 1, 1996 CHAP rate period; etc.
 - 3) "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.
 - 4) "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1, 1999, and as defined in Section 148.120(k)(5), plus the Medicaid obstetrical inpatient utilization rate, as described in Section 148.120(k)(6), as of July 1, 1999.
 - 5) "Medicaid general care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the

Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.

- 6) "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.
- 7) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.
- 8) "Medicaid obstetrical care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with Diagnosis Related Grouping (DRG) of 370 through 375; and specifically excludes Medicare/Medicaid crossover claims.
- 9) "Medicaid trauma admission" means those claims billed as admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.31, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through

887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925 through 925.2, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99.

- 10) "Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all Level II urban trauma centers.
- 11) "RCHAP general care admissions" means Medicaid General Care Admissions, as defined in subsection (g)(4) of this Section, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.
- 12) "RCHAP obstetrical care admissions" means Medicaid Obstetrical Care Admissions, as defined in subsection (g)(7) of this Section, with a Diagnosis Related Grouping (DRG) of 370 through 375, occurring in the CHAP base period.
- 13) "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.
- 14) "Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.
- 15) "Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; V27 through V27.9; V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

(Source: Amended by emergency rulemaking at 30 Ill. Reg. 11815, effective July 1, 2006, for a maximum of 150 days)

Section 148.296 Tertiary Care Adjustment Payments

Tertiary Care Adjustment Payments shall be made to all eligible hospitals, excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for inpatient admissions occurring on or after July 1, 2002, in accordance with this Section.

- a) Definitions. The definitions of terms used with reference to calculation of payments under this Section are as follows:

- 1) “Base Period Claims” means claims for inpatient hospital services with dates of service occurring in the Tertiary Adjustment Base Period that were subsequently adjudicated by the Department through December 31, 1999. For a general care hospital that includes a facility devoted exclusively to caring for children and that was separately licensed as a hospital by a municipality before September 30, 1998, Base Period Claims for services that may, in 89 Ill. Adm. Code 149.50(c)(3), be billed by a children’s hospital shall be attributed exclusively to the children’s facility. Base Period Claims shall exclude the following types:
 - A) Claims for which Medicare was liable in part or in full (“cross-over” claims);
 - B) Claims for transplantation services that were paid by the Department via form C-13, Invoice Voucher; and
 - C) Claims for services billed for exceptional care services as described at Section 148.50(c)(2)(A) and (B).
- 2) “Case Mix Index” (CMI), for a given hospital, means the sum of all Diagnosis Related Grouping (DRG) (see 89 Ill. Adm. Code 149) weighting factors for Base Period Claims divided by the total number of claims included in the sum, but excluding claims:
 - A) Reimbursed under a per diem rate methodology; and
 - B) For Delivery or Newborn Care.
- 3) “Case Mix Adjustment Factor” (CMAF) means the following:
 - A) For qualifying hospitals located in Illinois that, for Base Period Claims, had a CMI that is greater than the mean:
 - i) CMI of all Illinois cost-reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.040;
 - ii) CMI plus one standard deviation above the mean of all Illinois cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.250;
 - iii) CMI plus two standard deviations above the mean of all Illinois cost reporting hospitals, the CMAF shall be equal to 0.300.

- B) For qualifying hospitals located outside of Illinois that, for Base Period Claims, had a CMI that is greater than the mean:
 - i) CMI of all out-of-state cost reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.020;
 - ii) CMI plus one standard deviation above the mean of all out-of-state cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.125;
 - iii) CMI plus two standard deviations above the mean of all out-of-state cost reporting hospitals, the CMAF shall be equal to 0.150.
 - 4) "Delivery or Newborn Care" means inpatient hospital care, the claim for which was assigned by the Department to DRGs 370 through 375, 385 through 387, 389, 391 and 985 through 989.
 - 5) "Tertiary Adjustment Base Period" means calendar year 1998.
 - 6) "Tertiary Care Adjustment Rate Period" means, for fiscal year 2001, the three-month period beginning April 1, 2001, and for each subsequent fiscal year, the twelve-month period beginning July 1.
- b) Case Mix Adjustment

The Department shall make a Case Mix Adjustment to certain hospitals, as defined in this subsection (b).

 - 1) Qualifying Hospital. A hospital meeting both of the following criteria shall qualify for this payment:
 - A) A hospital that had 100 or more Qualified Admissions; and
 - B) For a hospital located:
 - i) in Illinois, has a CMI greater than or equal to the mean CMI for Illinois hospitals; or
 - ii) outside of Illinois, has a CMI greater than or equal to the mean CMI for out-of-state cost-reporting hospitals.
 - 2) Qualified Admission. For the purposes of this subsection (b), "Qualified Admission" shall mean a Base Period Claim excluding a claim:
 - A) Reimbursed under a per diem rate methodology; and
 - B) For Delivery or Newborn Care.
 - 3) Case Mix Adjustment. Each Qualifying Hospital will receive a payment equal to the product of:
 - A) The product of the hospital's:
 - i) number of Qualified Admissions; and
 - ii) CMAF; and
 - B) The sum of the hospital's:
 - i) rate for capital related costs in effect on July 1, 2000; and

- ii) the product of the hospital's CMI raised to the second power and the DRG PPS (Prospective Payment System) (see 89 Ill. Adm. Code 149) rate per discharge in effect on July 1, 2000.

c) DRG Adjustment

The Department shall make a DRG Adjustment to certain hospitals, as defined in this subsection (c).

- 1) Qualifying Hospital. A hospital that, during the Tertiary Adjustment Base Period, had at least one Qualified Admission shall qualify for this payment.
- 2) Qualified Admission. For the purposes of this subsection (c), "Qualified Admission" means a Base Period Claim that was:
 - A) Assigned by the Department to a DRG that:
 - i) had been assigned a weighting factor greater than 3.2000; and
 - ii) for which fewer than 200 Base Period Claims were adjudicated by the Department; and
 - B) Not a claim:
 - i) reimbursed under a per diem rate methodology;
 - ii) for Delivery or Newborn Care; or
 - iii) for a patient transferred to another facility as described at 89 Ill. Adm. Code 149.25(b)(2).
- 3) DRG Adjustment Rates. For each Qualified Admission, a Qualifying Hospital will receive a payment equal to the product of:
 - A) The hospital's DRG PPS rate per discharge in effect on July 1, 2000; and
 - B) The weighting factor assigned to the DRG to which the Qualified Admission was assigned by the Department; and
 - C) The constant 1.400.

d) Children's Hospital Adjustment

The Department shall make a Children's Hospital Adjustment to certain hospitals, as defined in this subsection (d).

- 1) Qualifying Hospital. A children's hospital, as defined at 89 Ill. Adm. Code 149.50(c)(3), shall qualify for this payment.
- 2) Qualified Days. For the purposes of this subsection (d), "Qualified Day" means a day of care that was provided in a Base Period Claim, excluding a claim:
 - A) For Delivery or Newborn Care;
 - B) Assigned by the Department to a DRG with an assigned weighting factor that is less than 1.0000; or

- C) For hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b).
 - 3) Children's Hospital Adjustment. A Qualifying Hospital shall receive a payment equal to the product of:
 - A) The sum of Qualified Days from the hospital's Base Period Claims; and
 - B) For Illinois hospitals with:
 - i) more than 5,000 Qualified Days, \$670.00; or
 - ii) 5,000 or fewer Qualified Days, \$300.00.
 - C) For out of state hospitals with:
 - i) more than 1,000 Qualified Days, \$670.00; or
 - ii) 1,000 or fewer Qualified Days, \$300.00.
- e) Primary Care Adjustment
The Department shall make a Primary Care Adjustment to certain hospitals, as defined in this subsection (e).
 - 1) Qualifying Hospital. A hospital located in Illinois that has at least one Qualifying Resident shall qualify for this payment.
 - 2) Qualifying Residents. For the purposes of this subsection (e), "Qualifying Residents" means the number of primary care residents, as reported on form HCFA 2552-96, Worksheet E-3, Part IV, line 1, column 1, for hospital fiscal years ending September 30, 1997, through September 29, 1998, used in the fiscal year 2002 Tertiary Care Adjustment Rate Period.
 - 3) Qualified Admission. For the purposes of this subsection (e), "Qualified Admission" shall mean a Base Period Claim excluding a claim:
 - A) For hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b) and reimbursed under a per diem rate methodology; and
 - B) For Delivery or Newborn Care.
 - 4) Primary Care Adjustment. A Qualifying Hospital will receive a payment equal to the product of:
 - A) The number of Qualifying Admissions during the Tertiary Adjustment Base Period;
 - B) \$4,675.00; and
 - C) The quotient of:
 - i) the number of Qualifying Residents,
 - ii) divided by the number of Qualifying Admissions.
- f) Long Term Stay Hospital Adjustment
The Department shall make a Long Term Stay Hospital Adjustment to certain hospitals, as defined in this subsection (f).
 - 1) Qualifying Hospital. A long term stay hospital, as defined at 89 Ill. Adm.

- Code 149.50(c)(4), that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, shall qualify for this payment.
- 2) **Qualified Days.** For the purposes of this subsection (f), “Qualified Day” means a day of care that was provided in a Base Period Claim, excluding claims for hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b).
 - 3) **Long Term Stay Hospital Adjustment Rates.** A Qualifying Hospital will receive payments equal to the product of:
 - A) The number of Qualified Days from all Base Period Claims; and
 - B) A constant that:
 - i) for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals plus one standard deviation above the mean, \$300.00; or
 - ii) for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, but less than one standard deviation above that mean, \$5.00.
- g) **Rehabilitation Hospital Adjustment**
The Department shall make a Rehabilitation Hospital Adjustment to certain hospitals as defined in this subsection (g).
- 1) **Qualifying Hospital.** A hospital that qualifies for the Rehabilitation Hospital Adjustment under the Critical Hospital Adjustment Payments (CHAP) program, as defined in Section 148.295(b), shall qualify for this payment.
 - 2) **Qualified Admission.** For the purposes of this subsection (g), “Qualified Admission” shall mean a Medicaid level I rehabilitation admission in the CHAP rate period, as defined in Section 148.295, for fiscal year 2001.
 - 3) **Rehabilitation Hospital Adjustment.** A Qualifying Hospital shall receive payment as follows:
 - A) For a hospital that had fewer than 60 Qualified Admissions, \$100,000.00.
 - B) For a hospital that had 60 or more Qualified Admissions, \$350,000.00.
- h) **Tertiary Care Adjustment**
- 1) The total annual adjustment to an eligible hospital shall be the sum of the adjustments for which the hospital qualifies under subsections (a) through (g) of this Section multiplied by 0.455.
 - 2) A total annual adjustment amount shall be paid to the hospital during the Tertiary Care Adjustment Rate Period in installments on, at least, a quarterly basis.

(Source: Amended at 26 Ill. Reg. 17775, effective November 27, 2002)

Section 148.297 Pediatric Outpatient Adjustment Payments

Pediatric Outpatient Adjustment Payments shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for outpatient services occurring on or after July 1, 1998, in accordance with this Section.

- a) To qualify for payments under this Section, a hospital must:
 - 1) be a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), and
 - 2) have a Pediatric Medicaid Outpatient Percentage greater than 80 percent during the Pediatric Outpatient Adjustment Base Period.
- b) Hospitals qualifying under this Section shall receive the following amounts for the Pediatric Outpatient Adjustment Rate Year for dates of services occurring on or after July 1, 1999:
 - 1) For out-of-state cost reporting hospitals with an MIUR that is less than 75 percent, the product of:
 - A) the hospital's MIUR plus 1.15, multiplied by
 - B) the number of Pediatric Adjustable Outpatient Services, multiplied by
 - C) \$169.00.
 - 2) For Illinois hospitals with an MIUR that is less than 75 percent, the product of:
 - A) the hospital's MIUR plus one, multiplied by
 - B) the number of Pediatric Adjustable Outpatient Services, multiplied by
 - C) \$169.00.
 - 3) For Illinois hospitals with an MIUR that is greater than or equal to 75 percent, the product of:
 - A) one and one-half the hospital's MIUR plus one, multiplied by
 - B) the number of Pediatric Adjustable Outpatient Services, multiplied by
 - C) \$169.00.
- c) In addition to the reimbursement rates described in subsection (b) of this Section, hospitals that have an MIUR that is greater than or equal to 80 percent shall receive an additional \$229,740.00 during the Pediatric Outpatient Adjustment Rate Year.
- d) Adjustments under this Section shall be paid at least quarterly.
- e) Definitions
 - 1) "Medicaid Inpatient Utilization Rate (MIUR)", as used in this Section, has the same meaning as ascribed in Section 148.120(k)(5), in effect for the rate period October 1, 1996, through September 30, 1997.
 - 2) "Pediatric Adjustable Outpatient Services" means the number of outpatient services, excluding procedure code 0080, adjudicated through a

UB92 billing form and grouped through the Hospital Ambulatory Care Groupings, as defined in Section 148.140(b)(1), during the Pediatric Outpatient Adjustment Base Period. For a hospital, which includes a facility devoted exclusively to caring for children, that is separately licensed as a hospital by a municipality, Pediatric Adjustment Outpatient Services will include psychiatric services (categories of service 27 or 28) for children less than 18 years of age, that are billed through the affiliated general care hospital.

- 3) “Pediatric Medicaid Outpatient Percentage” means a percentage that results from the quotient of the total Pediatric Adjustable Outpatient Services for persons less than 18 years of age divided by the total Pediatric Adjustable Outpatient Services for all persons, during the Pediatric Outpatient Adjustment Base Period.
- 4) “Pediatric Outpatient Adjustment Base Period” means all services billed to the Department, excluding procedure code 0080, with State Fiscal Year 1996 dates of service that were adjudicated by the Department on or before March 31, 1997.
- 5) “Pediatric Outpatient Adjustment Rate Year” means State Fiscal Year 1998 and each State Fiscal Year thereafter.

(Source: Amended at 26 Ill. Reg. 17775, effective November 27, 2002)

Section 148.298 Pediatric Inpatient Adjustment Payments

Pediatric Inpatient Adjustment Payments shall be made, on a quarterly basis, to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for inpatient services occurring on or after July 1, 1998, in accordance with this Section.

- a) To qualify for payments under this subsection (a), a hospital must be a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), that was licensed by a municipality on or before December 31, 1997. Hospitals qualifying under this subsection shall receive an adjustment for inpatient services equal to the product of the hospital's psychiatric and physical rehabilitation days, provided to children under 18 years of age during the adjustment base year, multiplied by \$816.00 per day. Payments under this subsection will be based on the following methodology:
 - 1) The calculation under this subsection (a) may not exceed more than 850 days.
 - 2) For the purposes of calculating payments under this subsection (a), the adjustment base year shall be psychiatric and physical rehabilitation days of care provided by the portion of the hospital that the Department does not recognize as a children's hospital. Such days include those provided in State fiscal year 1997 and adjudicated by the Department through March 31, 1998.
- b) In addition to the payments described under subsection (a) of this Section, any children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), will receive an additional adjustment equal to the product of the hospital's total paid days, excluding Medicare crossover claims, multiplied by \$113.00 per day. Such days include those provided in State fiscal year 1999 and adjudicated by the Department through May 31, 1999.
- c) For rate years occurring after State fiscal year 2000, total payments made under subsections (a) and (b) of this Section shall be paid at least quarterly.

(Source: Amended at 26 Ill. Reg. 17775, effective November 27, 2002)

Section 148.300 Payment

The Department will pay the full final rates calculated in Sections 148.250 - 148.290 for hospitals described in 89 Ill. Adm. Code 148.200(e).

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.310 Review Procedure

a) Inpatient Rate Reviews

- 1) Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of any rate for errors in calculation made by the Department. Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its rates. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- 2) Hospitals reimbursed in accordance with Sections 148.250 through 148.300 and 89 Ill. Adm. Code 149 with respect to per diem add-ons for capital may request that an adjustment be made to their base year costs to reflect significant changes in costs that have been mandated in order to meet State, federal or local health and safety standards, and that have occurred since the hospital's filing of the base year cost report. The allowable Medicare/Medicaid costs must be identified from the most recent audited cost report available. These costs must be significant, i.e., on a per unit basis, they must constitute one percent or more of the total allowable Medicaid/Medicare unit costs for the same time period. Appeals for base year cost adjustments must be submitted, in writing, to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its rates. Such request shall include a clear explanation of the cost change and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

b) Disproportionate Share (DSH) and Medicaid Percentage Adjustment (MPA) Determination Reviews

- 1) Hospitals shall be notified of their qualification for DSH and/or MPA payment adjustments and shall have an opportunity to request a review of the DSH and/or MPA add-on for errors in calculation made by the Department. Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its disproportionate share and/or Medicaid Percentage Adjustment qualification and add-on

calculations. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- 2) DSH and/or MPA determination reviews shall be limited to the following:
 - A) DSH and/or MPA Determination Criteria. The criteria for DSH determination shall be in accordance with Section 148.120. The criteria for MPA determination shall be in accordance with Section 148.122. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.
 - B) Medicaid Inpatient Utilization Rates.
 - i) Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(k)(4). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.
 - ii) Hospitals' Medicaid inpatient utilization rates, as defined in Section 148.120(k)(4), which have been derived from unaudited cost reports or HDSC forms, are not subject to the Review Procedure with the exception of errors in calculation by the Department. Pursuant to Section 148.120(c)(1)(B) and (c)(1)(C)(i) and (ii), hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH and/or MPA determination.
 - C) Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act, Section 148.120(a)(2) and (d), and Section 148.122(a)(2) and (c). Review shall be limited to verification that low income utilization rates were calculated in accordance with federal and State regulations.
 - D) Federally Designated Health Manpower Shortage Areas (HMSAs). Illinois hospitals located in federally designated HMSAs shall be identified in accordance with 42 CFR 5 (1989) and Section 148.122(a)(3) based upon the methodologies utilized by, and the most current information available to, the Department from the

federal Department of Health and Human Services as of June 30, 1992. Review shall be limited to hospitals in locations that have failed to obtain designation as federally-designated HMSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA as of June 30, 1992.

- E) **Excess Beds.** Excess bed information shall be determined in accordance with Public Act 86-268 (Section 148.122(a)(3) and 77 Ill. Adm. Code 1100) based upon the methodologies utilized by, and the most current information available to, the Illinois Health Facilities Planning Board as of July 1, 1991. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and utilized by the Department was incorrect.
 - F) **Medicaid Obstetrical Inpatient Utilization Rates.** Medicaid obstetrical inpatient utilization rates shall be calculated in accordance with Section 148.122(a)(4), (h)(2), (h)(3) and (h)(4). Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with State regulations.
- c) **Outlier Adjustment Reviews**

The Department shall make outlier adjustments to payment amounts in accordance with 89 Ill. Adm. Code 149.105 or Section 148.130, whichever is applicable. Hospitals shall be notified of the specific information that shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review of such specific information for errors in calculation made by the Department. Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of the specific information that shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- d) **Cost Report Reviews**

- 1) Cost reports are required from:
 - A) All enrolled hospitals within the State of Illinois;
 - B) All out-of-state hospitals providing 100 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program; and
 - C) All hospitals not located in Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the DRG PPS).
 - 2) The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days after the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report, which may contain adjustments and revisions that may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis that support the request for review. No additional data shall be accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- e) Trauma Center Adjustment Reviews
- 1) The Department shall make trauma care adjustments in accordance with Section 148.290(c). Hospitals shall have the right to appeal the trauma center adjustment calculations if it is believed that a technical error has been made in the calculation by the Department.

- 2) Trauma level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating that the information supplied to and utilized by the Department was incorrect.
 - 3) Appeals under this subsection (e) must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- f) **Medicaid High Volume Adjustment Reviews**
The Department shall make Medicaid high volume adjustments in accordance with Section 148.290(d). Review shall be limited to verification that the Medicaid inpatient days were calculated in accordance with Section 148.120. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- g) **Sole Community Hospital Designation Reviews**
The Department shall make sole community hospital designations in accordance with 89 Ill. Adm. Code 149.125(b). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.
- h) **Geographic Designation Reviews**

- 1) The Department shall make rural hospital designations in accordance with Section 148.25(g)(3). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.
 - 2) The Department shall make urban hospital designations in accordance with Section 148.25(g)(4). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.
- i) Critical Hospital Adjustment Payment (CHAP) Reviews
- 1) The Department shall make CHAP in accordance with Section 148.295. Hospitals shall be notified in writing of the results of the CHAP determination and calculation, and shall have the right to appeal the CHAP calculation or their ineligibility for the CHAP if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for CHAP and payment adjustment amounts, or a letter of notification that the hospital does not qualify for the CHAP. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
 - 2) CHAP determination reviews shall be limited to the following:
 - A) Federally Designated Health Professional Shortage Areas (HPSAs). Illinois hospitals located in federally designated HPSAs

shall be identified in accordance with 42 CFR 5, and Section 148.295(a)(3)(B) and (b)(3) based upon the methodologies utilized by, and the most current information available to, the Department from the federal Department of Health and Human Services as of the last day of June preceding the CHAP rate period. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HPSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HPSA as of the last day of June preceding the CHAP rate period.

- B) Trauma level designation. Trauma level designation is obtained from the Illinois Department of Public Health as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.
- C) Accreditation of Rehabilitation Facilities. Accreditation of rehabilitation facilities shall be obtained from the Commission on Accreditation of Rehabilitation Facilities as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Commission, substantiating that the information supplied to and utilized by the Department was incorrect.
- D) Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(k)(5). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.
- E) Graduate Medical Education Programs. Graduate Medical Education program information shall be obtained from the most recently published report of the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from

the above, substantiating that the information supplied to and utilized by the Department was incorrect.

- j) Tertiary Care Adjustment Payment Reviews. The Department shall make Tertiary Care Adjustment Payments in accordance with Section 148.296. Hospitals shall be notified in writing of the results of the Tertiary Care Adjustment Payments determination and calculation, and shall have the right to appeal the Tertiary Care Adjustment Payments calculation or their ineligibility for Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Tertiary Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- k) Pediatric Outpatient Adjustment Payment Reviews. The Department shall make Pediatric Outpatient Adjustment payments in accordance with Section 148.297. Hospitals shall be notified in writing of the results of the determination and calculation, and shall have the right to appeal the calculation or their ineligibility for payments under Section 148.297 if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification under Section 148.297 and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- l) Pediatric Inpatient Adjustment Payment Reviews. The Department shall make Pediatric Inpatient Adjustment payments in accordance with Section 148.298. Hospitals shall be notified in writing of the results of the determination and calculation, and shall have the right to appeal the calculation or their ineligibility for payments under Section 148.298 if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its

qualification under Section 148.298 and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- m) **Safety Net Adjustment Payment Reviews.** The Department shall make Safety Net Adjustment Payments in accordance with Section 148.126. Hospitals shall be notified in writing of the results of the Safety Net Adjustment Payment determination and calculation, and shall have the right to appeal the Safety Net Adjustment Payment calculation or their ineligibility for Safety Net Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Safety Net Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Safety Net Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- n) **Psychiatric Adjustment Payment Reviews.** The Department shall make Psychiatric Adjustment Payments in accordance with Section 148.105. Hospitals shall be notified in writing of the results of the Psychiatric Adjustment Payments determination and calculation, and shall have a right to appeal the Psychiatric Adjustment Payments calculation or their ineligibility for Psychiatric Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- o) **Rural Adjustment Payment Reviews.** The Department shall make Rural Adjustment Payments in accordance with Section 148.115.

- 1) Hospitals shall be notified in writing of the results of the Rural Adjustment Payments determination and calculation, and shall have a right to appeal the Rural Adjustment Payments calculation or their ineligibility for Rural Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department.
 - 2) The designation of Critical Access Provider or Necessary Provider, which are qualifying criteria for Rural Adjustment Payments (see Section 148.115(a)), is obtained from the Illinois Department of Public Health (IDPH) as of the first day of July preceding the Rural Adjustment Payment rate period. Review shall be limited to requests accompanied by documentation from IDPH, substantiating that the information supplied to and utilized by the Department was incorrect.
 - 3) The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rural Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rural Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- p) Supplemental Tertiary Care Adjustment Payment Reviews. The Department shall make Supplemental Tertiary Care Adjustment Payments in accordance with Section 148.85. Hospitals shall be notified in writing of the results of the Supplemental Tertiary Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Tertiary Care Adjustment Payments calculation or their ineligibility for Supplemental Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Tertiary Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- q) Medicaid Inpatient Utilization Rate Adjustment Payment Reviews. The Department shall make Medicaid Inpatient Utilization Rate Adjustment Payments in accordance with Section 148.90. Hospitals shall be notified in writing of the results of the Medicaid Inpatient Utilization Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Inpatient Utilization Rate Adjustment Payments calculation or their ineligibility for Medicaid Inpatient Utilization Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Inpatient Utilization Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Inpatient Utilization Rate Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- r) Medicaid Outpatient Utilization Rate Adjustment Payment Reviews. The Department shall make Medicaid Outpatient Utilization Rate Adjustment Payments in accordance with Section 148.95. Hospitals shall be notified in writing of the results of the Medicaid Outpatient Utilization Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Outpatient Utilization Rate Adjustment Payments calculation or their ineligibility for Medicaid Outpatient Utilization Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Outpatient Utilization Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Outpatient Utilization Rate Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- s) Outpatient Rural Hospital Adjustment Payment Reviews. The Department shall make Outpatient Rural Adjustment Payments in accordance with Section 148.100. Hospitals shall be notified in writing of the results of the Outpatient Rural Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Rural Adjustment Payments calculation or their ineligibility for Outpatient Rural Adjustment Payments if the hospital believes

that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Rural Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Rural Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- t) Outpatient Service Adjustment Payment Reviews. The Department shall make Outpatient Service Adjustment Payments in accordance with Section 148.103. Hospitals shall be notified in writing of the results of the Outpatient Service Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Service Adjustment Payments calculation or their ineligibility for Outpatient Service Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Service Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Service Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- u) Psychiatric Base Rate Adjustment Payment Reviews. The Department shall make Psychiatric Base Rate Adjustment Payments in accordance with Section 148.110. Hospitals shall be notified in writing of the results of the Psychiatric Base Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Psychiatric Base Rate Adjustment Payments calculation or their ineligibility for Psychiatric Base Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Base Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Base Rate Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- v) High Volume Adjustment Payment Reviews. The Department shall make High Volume Adjustment Payments in accordance with Section 148.112. Hospitals shall be notified in writing of the results of the High Volume Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the High Volume Adjustment Payments calculation or their ineligibility for High Volume Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for High Volume Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for High Volume Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- w) Medicaid Eligibility Payment Reviews. The Department shall make Medicaid Eligibility Payments in accordance with Section 148.402. Hospitals shall be notified in writing of the results of the Medicaid Eligibility Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Eligibility Payments calculation or their ineligibility for Medicaid Eligibility Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Eligibility Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Eligibility Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- x) Medicaid High Volume Adjustment Payment Reviews. The Department shall make Medicaid High Volume Payments in accordance with Section 148.404. Hospitals shall be notified in writing of the results of the Medicaid High Volume Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid High Volume Payments calculation or their ineligibility for Medicaid High Volume Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for

Medicaid High Volume Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid High Volume Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- y) Intensive Care Adjustment Payment Reviews. The Department shall make Intensive Care Payments in accordance with Section 148.406. Hospitals shall be notified in writing of the results of the Intensive Care Payments determination and calculation. Hospitals shall have a right to appeal the Intensive Care Payments calculation or their ineligibility for Intensive Care Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Intensive Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Intensive Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- z) Trauma Center Adjustment Payment Reviews. The Department shall make Trauma Center Adjustment Payments in accordance with Section 148.408. Hospitals shall be notified in writing of the results of the Trauma Center Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Trauma Center Adjustment Payments calculation or their ineligibility for Trauma Center Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Trauma Center Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Trauma Center Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- aa) Psychiatric Rate Adjustment Payment Reviews. The Department shall make Psychiatric Rate Adjustment Payments in accordance with Section 148.410. Hospitals shall be notified in writing of the results of the Psychiatric Rate Adjustment Payments determination and calculation. Hospitals shall have a right

to appeal the Psychiatric Rate Adjustment Payments calculation or their ineligibility for Psychiatric Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Rate Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- bb) Rehabilitation Adjustment Payment Reviews. The Department shall make Rehabilitation Adjustment Payments in accordance with Section 148.412. Hospitals shall be notified in writing of the results of the Rehabilitation Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Rehabilitation Adjustment Payments calculation or their ineligibility for Rehabilitation Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rehabilitation Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rehabilitation Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- cc) Supplemental Tertiary Care Adjustment Payment Reviews. The Department shall make Supplemental Tertiary Care Adjustment Payments in accordance with Section 148.414. Hospitals shall be notified in writing of the results of the Supplemental Tertiary Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Tertiary Care Adjustment Payments calculation or their ineligibility for Supplemental Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Tertiary Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The

Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- dd) Crossover Percentage Adjustment Payment Reviews. The Department shall make Crossover Percentage Adjustment Payments in accordance with Section 148.416. Hospitals shall be notified in writing of the results of the Crossover Percentage Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Crossover Percentage Adjustment Payments calculation or their ineligibility for Crossover Percentage Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Crossover Percentage Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Crossover Percentage Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- ee) Long Term Acute Care Hospital Adjustment Payment Reviews. The Department shall make Long Term Acute Care Hospital Adjustment Payments in accordance with Section 148.418. Hospitals shall be notified in writing of the results of the Long Term Acute Care Hospital Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Long Term Acute Care Hospital Adjustment Payments calculation or their ineligibility for Long Term Acute Care Hospital Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Long Term Acute Care Hospital Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Long Term Acute Care Hospital Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- ff) Obstetrical Care Adjustment Payment Reviews. The Department shall make Obstetrical Care Adjustment Payments in accordance with Section 148.420. Hospitals shall be notified in writing of the results of the Obstetrical Care Adjustment Payments determination and calculation. Hospitals shall have a right

to appeal the Obstetrical Care Adjustment Payments calculation or their ineligibility for Obstetrical Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Obstetrical Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Obstetrical Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- gg) Outpatient Access Payment Reviews. The Department shall make Outpatient Access Payments in accordance with Section 148.422. Hospitals shall be notified in writing of the results of the Outpatient Access Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Access Payments calculation or their ineligibility for Outpatient Access Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Access Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Access Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- hh) Outpatient Utilization Payment Reviews. The Department shall make Outpatient Utilization Payments in accordance with Section 148.424. Hospitals shall be notified in writing of the results of the Outpatient Utilization Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Utilization Payments calculation or their ineligibility for Outpatient Utilization Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Utilization Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Utilization Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- ii) Outpatient Complexity of Care Adjustment Payment Reviews. The Department shall make Outpatient Complexity of Care Adjustment Payments in accordance with Section 148.426. Hospitals shall be notified in writing of the results of the Outpatient Complexity of Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Complexity of Care Adjustment Payments calculation or their ineligibility for Outpatient Complexity of Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Complexity of Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Complexity of Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- jj) Rehabilitation Hospital Adjustment Payment Reviews. The Department shall make Rehabilitation Hospital Adjustment Payments in accordance with Section 148.428. Hospitals shall be notified in writing of the results of the Rehabilitation Hospital Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Rehabilitation Hospital Adjustment Payments calculation or their ineligibility for Rehabilitation Hospital Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rehabilitation Hospital Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rehabilitation Hospital Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- kk) Perinatal Outpatient Adjustment Payment Reviews. The Department shall make Perinatal Outpatient Adjustment Payments in accordance with Section 148.430. Hospitals shall be notified in writing of the results of the Perinatal Outpatient Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Perinatal Outpatient Adjustment Payments calculation or their ineligibility for Perinatal Outpatient Adjustment Payments if the hospital believes

that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Perinatal Outpatient Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Perinatal Outpatient Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- ll) **Supplemental Psychiatric Adjustment Payment Reviews.** The Department shall make Supplemental Psychiatric Adjustment Payments in accordance with Section 148.432. Hospitals shall be notified in writing of the results of the Supplemental Psychiatric Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Psychiatric Adjustment Payments calculation or their ineligibility for Supplemental Psychiatric Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Psychiatric Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Psychiatric Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- mm) **Outpatient Community Access Adjustment Payment Reviews.** The Department shall make Outpatient Community Access Adjustment Payments in accordance with Section 148.434. Hospitals shall be notified in writing of the results of the Outpatient Community Access Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Community Access Adjustment Payments calculation or their ineligibility for Outpatient Community Access Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Community Access Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Community Access Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation

that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

- nn) For purposes of this Section, the term "post marked" means the date of processing by the United States Post Office or any independent carrier service.
- oo) The review procedures provided for in this Section may not be used to submit any new or corrected information that was required to be submitted by a specific date in order to qualify for a payment or payment adjustment. In addition, only information that was submitted expressly for the purpose of qualifying for the payment or payment adjustment under review shall be considered by the Department. Information that has been submitted to the Department for other purposes will not be considered during the review process.

(Source: Amended at 30 Ill. 383, effective December 28, 2005)

Section 148.320 Alternatives

- a) The provisions of Sections 148.250 through 148.310 of this Part shall be in effect during the fiscal year for so long as the Director of the Department finds that:
 - 1) The total number of hospitals agreeing to be reimbursed pursuant to the provisions of this Part is sufficient to assure that medical assistance recipients have reasonable access to hospital services. In making this determination, factors considered by the Department include but are not limited to service availability and the number of recipients within a geographic area, recipient travel time to obtain services, and availability of a range of services within the geographic area.
 - 2) The provisions are approved by the Department of Health and Human Services in the State Title XIX Plan.
 - 3) The Department has not been enjoined, restrained or otherwise delayed or prohibited by Court order or actions of entities other than the Department from enforcing the provisions.
- b) If any of the conditions specified above fail to occur, alternative service coverage and reimbursement limitations shall be implemented to assure that payments for hospital services during a fiscal year will be approximately the same as would have been made under this Part.

(Source: Amended at 17 Ill. Reg. 3296, effective March 1, 1993)

Section 148.330 Exemptions

Nothing in these rules is intended to prevent a hospital from individually negotiating with the Department to set up an alternate methodology for reimbursement that results in an expenditure which does not exceed the expenditure which would otherwise be made under this rule.

(Source: Recodified from 89 Ill. Adm. Code 140.375 at 13 Ill. Reg. 9572)

Section 148.340 Subacute Alcoholism and Substance Abuse Treatment Services

- a) Payment may be made for subacute alcoholism and other drug abuse treatment services provided by:
 - 1) A provider licensed by the Illinois Department of Human Services under the provisions of 77 Ill. Adm. Code 2060.
 - 2) A provider licensed by the Illinois Department of Public Health under the provisions of 77 Ill. Adm. Code 250.2830(b) and (c).
 - 3) Psychiatrists for ancillary diagnostic services.
- b) Providers must be certified for participation by the Department of Human Services in accordance with 77 Ill. Adm. Code 2090.
- c) Certified providers shall comply with, and provide all services in accordance with, all provisions of 77 Ill. Adm. Code 2090.
- d) Providers shall enroll for participation in the Medical Assistance Program as provided in 89 Ill. Adm. Code 140.11.

(Source: Amended at 24 Ill. Reg. 11846, effective August 1, 2000)

Section 148.350 Definitions (Repealed)

(Source: Repealed at 24 Ill. Reg. 11846, effective August 1, 2000)

Section 148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services
(Repealed)

(Source: Repealed at 24 Ill. Reg. 11846, effective August 1, 2000)

Section 148.368 Volume Adjustment (Repealed)

(Source: Peremptory repealer at 8 Ill. Reg. 18151, effective September 18, 1984)

Section 148.370 Payment for Subacute Alcoholism and Substance Abuse Treatment Services

- a) The amount approved for payment for alcoholism and substance abuse treatment is based on the type and amount of services required by and actually delivered to a recipient. The amount is determined in accordance with prospective rates developed by the Department of Human Services and approved and adopted by the Department of Public Aid (see 77 Ill. Adm. Code 2090.70). The adopted rate shall not exceed the charges to the general public.
- b) Rates are generated through the application of formal methodologies specific to each category in accordance with the specifications in 77 Ill. Adm. Code 2090.35, 2090.40 and 2090.70. Rate appeals are allowable pursuant to the specifications in 77 Ill. Adm. Code 2090.80.

(Source: Amended at 24 Ill. Reg. 11846, effective August 1, 2000)

Section 148.380 Rate Appeals for Subacute Alcoholism and Substance Abuse Treatment
Services (Repealed)

(Source: Repealed at 24 Ill. Reg. 11846, effective August 1, 2000)

Section 148.390 Hearings

- a) The Department may initiate administrative proceedings pursuant to 89 Ill. Adm. Code Part 104, Subpart C, to suspend or terminate certification and eligibility to participate in the Illinois Medical Assistance Program where the provider:
 - 1) Has failed to comply with 77 Ill. Adm. Code 2090.40; and/or
 - 2) Does not have a valid license for an enrolled treatment service category issued by the appropriate licensing authority; and/or
 - 3) Any of the grounds for payment recovery or termination set forth in 89 Ill. Adm. Code 140.15 or 140.16 are present.
- b) When a proceeding is initiated against providers of alcoholism or substance abuse services, the Department shall notify the provider of the intended action(s). Notice, service and proof of service shall be in accordance with the "Rules of Practice For Medical Vendor Administrative Proceedings" (89 Ill. Adm. Code 104: Subpart C).
- c) All hearings held pursuant to these rules shall be conducted by an attorney designated by the Director of the Department as a hearing officer and said hearing shall be conducted under and governed by the applicable "Rules of Practice For Medical Vendor Administrative Proceedings" promulgated by the Department (Ill. Adm. Code 104: Subpart C).
- d) The hearing officer shall prepare a written report of the case which shall contain findings of fact and recommended decisions with regard to the issues of recoupment, certification and continued participation in the Medicaid Program. The Associate Director of the Office of Alcoholism and Substance Abuse (Department of Human Services) shall also make a recommendation that final shall be in writing and forwarded to the Director of IDPA. The Director of the Department shall then make a final decision based on the findings of fact and all recommendations. A final administrative decision shall be issued in writing and contain findings of fact and the final determinations concerning recoupment, certification and continued participation in the Medicaid Program. A copy of the decision shall be served on each party.

(Source: Amended at 24 Ill. Reg. 11846, effective August 1, 2000)

Section 148.400 Special Hospital Reporting Requirements

Corrective Action Plans. Hospitals are responsible for assuring that services provided to Medicaid program participants meet or exceed the appropriate standards for care. Any provider that is under any corrective action plan(s), while enrolled with the Department, by any licensing, certification and/or accreditation authority, including, but not limited to, the Illinois Department of Public Health, the Federal Department of Health and Human Services, a peer review organization, and/or the Joint Commission for Accreditation of Health Care Organization, must report the request for such corrective action plans to the Department. Information submitted will remain confidential.

(Source: Added at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.402 Medicaid Eligibility Payments

- a) **Qualifying Criteria.** Medicaid Eligibility Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it was assessed as described in 89 Ill. Adm. Code 140.80 for the rate year 2006 determination.
- b) The following classes of hospitals are ineligible for Medicaid Eligibility Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- c) **Medicaid Eligibility Payments**
 - 1) A hospital qualifying under subsection (a) of this Section shall receive payment equal to the product of \$430 multiplied by the qualifying hospital's Medicaid admissions in the Medicaid eligibility base year, multiplied by the change in the growth percentage of Medicaid clients within the hospital's county from State fiscal year 1998 to State fiscal year 2003.
 - 2) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being preformed under this subsection(c).
- d) **Payment to a Qualifying Hospital**
 - 1) For the Medicaid eligibility adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met

shall be paid within 100 days after the conditions described in subsection (f) have been met.

- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

- 1) “Growth percentage” means, for a given hospital, the percentage of change in the growth of Medicaid clients within the county where the hospital is located from 1998 to 2003.
- 2) “Medicaid admissions” means, for a given hospital, the sum of admissions of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department’s paid claims data for admissions occurring in the Medicaid eligibility base period that were adjudicated by the Department through June 30, 2004.
- 3) “Medicaid eligibility adjustment period” means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 4) “Medicaid eligibility base period” means the 12-month period beginning on July 1, 2002, and ending on June 30, 2003.

f) Payment Limitations: Payments under this Section are not due and payable until:

- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.404 Medicaid High Volume Adjustment Payments

- a) Qualifying Criteria. Medicaid High Volume Adjustment Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it is:
 - 1) an Illinois hospital that did not qualify for Medicaid Percentage Adjustments as described in Section 148.122 for the 12-month period beginning on October 1, 2004 and provided more than 10,000 Medicaid inpatient days in the Medicaid high volume base period; or
 - 2) an Illinois general acute care hospital as defined in Section 148.270(c)(1) that did qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 for the 12-month period beginning on October 1, 2004 and provided more than 21,000 Medicaid inpatient days in the Medicaid high volume base period.
- b) The following classes of hospitals are ineligible for High Volume Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- c) Medicaid High Volume Adjustment Payments
 - 1) For a hospital qualifying under subsection (a)(1) of this Section, payment is as follows:
 - A) A hospital that:
 - i) provided less than or equal to 14,500, but more than 10,000, Medicaid inpatient days in the Medicaid high volume base period, shall receive payments equal to the product of \$90 multiplied by the qualifying hospital's Medicaid inpatient days;

- ii) provided less than or equal to 18,500, but more than 14,500, Medicaid inpatient days in the Medicaid high volume base period shall receive payments equal to the product of \$135 multiplied by the qualifying hospital's Medicaid inpatient days;
 - iii) provided less than or equal to 20,000, but more than 18,500, Medicaid inpatient days in the Medicaid high volume base period shall receive payments equal to the product of \$225 multiplied by the qualifying hospital's Medicaid inpatient days; or
 - iv) provided 20,000 or more Medicaid inpatient days in the Medicaid high volume base period shall receive payments equal to the product of \$900 multiplied by the qualifying hospital's Medicaid inpatient days.
 - B) Payments will be the lesser of the calculation described in subsection (c)(1)(A)(i), (c)(1)(A)(ii), (c)(1)(A)(iii), and (c)(1)(A)(iv) or \$19 million dollars.
 - 2) For a hospital qualifying under subsection (a)(2) of this Section:
 - A) Payment equal to the product of \$35 multiplied by the qualifying hospital's Medicaid inpatient days.
 - B) Payments will be the lesser of the calculation described in subsection (c)(2)(A) or \$1,200,000.
 - 3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection.
- d) Payment to a Qualifying Hospital
- 1) For the Medicaid high volume adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of

the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

- 1) “Medicaid high volume adjustment period” means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 2) “Medicaid high volume base period” means the cost report on file with the Department on July 1, 2004, for the hospital’s fiscal year ending in 2002.
- 3) “Medicaid inpatient days” means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as contained in the hospital’s cost report on file with the Department as of July 1, 2004, for the hospital’s fiscal year ending in 2002.

f) Payment Limitations: Payments under this Section are not due and payable until:

- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.406 Intensive Care Adjustment Payments

- a) Qualifying Criteria. Intensive Care Adjustment Payments shall be made to qualifying Illinois general acute care hospitals as described in Section 148.270(c)(1). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if the hospital is located in a large urban area and has a ratio of Medicaid intensive care days to total Medicaid days greater than 19 percent for the intensive care adjustment period.
- b) The following classes of hospitals are ineligible for Intensive Care Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- c) Intensive Care Adjustment Payments
 - 1) Each qualifying hospital with an intensive care ratio of less than 30 percent, shall receive payment equal to the product of:
 - A) The ratio of Medicaid intensive care days to total Medicaid days;
 - B) Multiplied by total Medicaid days;
 - C) Multiplied by \$1,000.
 - 2) Each qualifying hospital with an intensive care ratio percentage equal to or greater than 30 percent shall receive payment equal to the product of the:
 - A) Ratio of Medicaid intensive care days to total Medicaid days;
 - B) Multiplied by total Medicaid days;
 - C) Multiplied by \$2,800.

- 3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).
- d) Payment to a Qualifying Hospital
- 1) For the intensive care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.
 - 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- e) Definitions
- 1) “Intensive care adjustment period” means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 2) “Intensive care base period” means the cost report on file with the Department on July 1, 2004, for the hospital’s fiscal year ending in 2002.
 - 3) “Large urban area” means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and with an urban hospital as described in Section 148.25(g)(4).
 - 4) “Medicaid intensive care days” means, for a given hospital, the sum of days of inpatient hospital service for intensive care days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as contained in the hospital’s cost report on file with the Department as of July 1, 2004, for the hospital’s fiscal year ending in 2002.

- 5) “Total Medicaid inpatient days” means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as contained in the hospital’s cost report on file with the Department as of July 1, 2004, for the hospital’s fiscal year ending in 2002.
- f) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.408 Trauma Center Adjustment Payments

- a) Qualifying Criteria. Trauma Center Adjustment Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it was a general acute care hospital that, as of January 1, 2005 was considered a trauma center and meets the requirements specified in subsection (c).
- b) The following classes of hospitals are ineligible for Trauma Center Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- c) Trauma Center Adjustment Payments
 - 1) Level I Trauma Center Adjustment Payments
 - A) For an Illinois general acute care hospital that was considered a Level I trauma center as of January 1, 2005, that is located in a large urban area or an other urban area that qualified for Medicaid Percentage Adjustments as described in Section 148.122 as of October 1, 2004, shall receive payments equal to the product of \$800 multiplied by the qualifying hospital's Medicaid intensive care unit (ICU) days in the trauma base period.
 - i) For a hospital located in a large urban area outside of a city with a population in excess of one million people, the Department shall pay an amount equal to the Level I Trauma Center Adjustment Payment calculated in subsection (c)(1)(A) of this Section multiplied by 4.5.
 - ii) For a hospital located in an other urban area, the Department shall pay an amount equal to the Level I Trauma Center Adjustment Payment calculated in (c)(1)(A) multiplied by 8.5.

2) Level II Trauma Center Adjustment Payments

- A) For an Illinois general acute care hospital that was considered a Level II trauma center as of January 1, 2005 and is located in a county with a population in excess of three million people, the payment shall equal:
- i) A hospital qualifying under subsection (c)(2)(A) of this Section shall be paid \$4,000 per day for the first 500 Medicaid inpatient days in the trauma base period.
 - ii) A hospital qualifying under subsection (c)(2)(A) of this Section shall be paid \$2,000 per day for the Medicaid inpatient days between 501 and 1,500 in the trauma base period.
 - iii) A hospital qualifying under subsection (c)(2)(A) of this Section shall be paid \$100 per day for each Medicaid inpatient day over 1,500 in the trauma base period.
- B) For an Illinois general acute care hospital that was considered a Level II trauma center as of January 1, 2005, and is located in a large urban area outside of a county with a population in excess of three million people and, as of January 1, 2005, was designated a Level III perinatal center or designated a Level II or II+ perinatal center that has a ratio of Medicaid ICU days to total Medicaid days greater than five percent, the payment shall equal:
- i) A hospital qualifying under subsection (c)(2)(B) of this Section shall be paid \$4,000 per day for the first 500 Medicaid inpatient days in the trauma base period.
 - ii) A hospital qualifying under subsection (c)(2)(B) of this Section shall be paid \$2,000 per day for the Medicaid inpatient days between 501 and 1,500 in the trauma base period.
 - iii) For a hospital qualifying under subsection (c)(2)(B) of this Section shall be paid \$100 per day for each Medicaid inpatient day over 1,500 in the trauma base period.

- 3) Pediatric Trauma Center Adjustment Payments
 - A) Qualifying Criteria: Payment shall be for all Illinois children's hospitals designated as Level I pediatric trauma centers that provided more than 30,000 Medicaid days in State fiscal year 2003 and those out-of-state Level I pediatric trauma centers that provided more than 700 Illinois Medicaid admissions in State fiscal year 2003.
 - B) A hospital qualifying under subsection (c)(3)(A) of this Section shall receive payment equal to the product of \$325 multiplied by the hospital's Illinois Medicaid ICU days.
 - C) For out-of-state hospitals qualifying under subsection (c)(3)(A), the amount calculated under subsection (c)(3)(B) shall be multiplied by 2.25.
 - 4) A hospital that enrolled to provide Medicaid services during fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).
 - 5) Notwithstanding any other provisions of this subsection (c), a children's hospital as defined at 89 Ill. Adm. Code 149.49(c)(3)(b), is not eligible for the payments described in subsections (c)(1) and (c)(2) of this Section.
- d) Payment to a Qualifying Hospital
- 1) For the trauma center adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) being met shall be paid within 100 days after the conditions described in subsection (f) of this Section have been met.
 - 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- e) Definitions

- 1) “Large urban area” means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and with an urban hospital as described in Section 148.25(g)(4).
 - 2) “Medicaid inpatient days” means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as contained in the hospital’s cost report on file with the Department as of July 1, 2004, for the hospital’s fiscal year ending in 2002.
 - 3) “Medicaid intensive care unit days” means, for a given hospital, the number of hospital inpatient days during which Medicaid recipients received intensive care services from the hospital, as determined from the hospital’s 2002 Medicaid cost report on file with the Department on July 1, 2004.
 - 4) “Other urban area” means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a city with a population in excess of 50,000 or with a total population in excess of 100,000, and with an urban hospital as described in Section 148.25(g)(4).
 - 5) “Trauma center adjustment period” means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006 and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 6) “Trauma center base period” means days reported in the hospital’s 2002 Medicaid cost report on file with the Department on July 1, 2004.
- f) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.410 Psychiatric Rate Adjustment Payments

- a) Qualifying Criteria: Psychiatric Rate Adjustment Payments described in subsection (b) of this Section shall be made to an Illinois psychiatric hospital and an Illinois general acute care hospital that has a distinct part psychiatric unit, excluding the following hospitals:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) Psychiatric Rate Adjustment Payments
 - 1) For a hospital qualifying under subsection (a) of this Section, the Department shall pay an amount equal to \$420 less the hospital's per diem rate for Medicaid inpatient psychiatric services, in effect on July 1, 2002, multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period. In no event, however, shall that amount be less than zero.
 - 2) For a hospital qualifying under subsection (a) of this Section whose inpatient psychiatric per diem rate is greater than \$420, the Department shall pay an amount equal to \$40 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period.
 - 3) For an Illinois psychiatric hospital located in a county with a population in excess of three million people that did not qualify for Medicaid Percentage Adjustments, as described in Section 148.122, for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal to \$150 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period.
 - 4) For an Illinois psychiatric hospital located in a county with a population in excess of three million people, but outside of a city with a population in excess of one million people, and did qualify for Medicaid Percentage Adjustments, as described in Section 148.122, for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal

to \$20 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period.

c) Payment to a Qualifying Hospital

- 1) For the psychiatric rate adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.
- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

- 1) “Medicaid inpatient psychiatric days” means, for a given hospital, the sum of days of inpatient psychiatric hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department’s paid claims data for admissions occurring in the psychiatric base period that were adjudicated by the Department through June 30, 2004.
- 2) “Psychiatric rate adjustment period” means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 3) “Psychiatric rate base period” means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.

e) Payment Limitations: Payments under this Section are not due and payable until:

- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.412 Rehabilitation Adjustment Payments

- a) Qualifying Criteria. Rehabilitation Adjustment Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment:
 - 1) if it is an Illinois general acute-care hospital, as described in Section 148.270(c)(1), located in a large urban area, with a rehabilitation unit that has 40 rehabilitation beds or more based upon the 2003 Medicaid cost report on file with the Department as of March 31, 2005; or
 - 2) if it is an Illinois rehabilitation hospital, as defined at 89 Ill. Adm. Code 149.50(c)(2), that did not qualify for Medicaid Percentage Adjustment Payments under Section 148.122 for the 12-month period beginning on October 1, 2004.
- b) The following classes of hospitals are ineligible for Rehabilitation Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- c) Rehabilitation Adjustment Payments
 - 1) For a hospital qualifying under subsection (a)(1) of this Section, the Department shall pay the product of \$230 multiplied by the hospital's Medicaid inpatient days.
 - 2) For a hospital qualifying under subsection (a)(2) of this Section, the Department shall pay an amount equal to the product of \$200 multiplied by the hospital's Medicaid inpatient days.
 - 3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

- 1) For the rehabilitation adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.
- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

- 1) “Large urban area” means, an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and with an urban hospital as described in Section 148.25(g)(4).
- 2) “Medicaid inpatient days” means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department’s paid claims data for admissions occurring in the rehabilitation base period that was adjudicated by the Department through June 30, 2004.
- 3) “Rehabilitation adjustment period” means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006; the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 4) “Rehabilitation base period” means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.

f) Payment Limitations: Payments under this Section are not due and payable until:

- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.414 Supplemental Tertiary Care Adjustment Payments

- a) Qualifying Criteria: Supplemental Tertiary Care Adjustment Payments, as described in subsection (b) of this Section, shall be made to all qualifying hospitals. An Illinois hospital shall qualify for payment if it was deemed eligible for payments under the Tertiary Care Adjustment Payments for fiscal year 2005, as described in Section 148.296, excluding:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) Supplemental Tertiary Care Adjustment Payments will be made to qualifying hospitals and will equal the product of the hospital's fiscal year 2005 tertiary care adjustment as described at Section 148.296 multiplied by 2.5.
- c) Payment to a Qualifying Hospital
 - 1) For the supplemental tertiary care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.
 - 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- d) "Tertiary care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, means the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- e) Payment Limitations: Payments under this Section are not due and payable until:

- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.416 Crossover Percentage Adjustment Payments

- a) **Qualifying Criteria.** Crossover Percentage Adjustment Payments shall be made to qualifying hospitals as defined in this subsection (a) of this Section. A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it is an Illinois general acute care hospital, as described in Section 148.270(c)(1), excluding any hospital defined as a cancer center hospital, located in an urban area, that provided over 500 days of inpatient care to Medicaid recipients, that had a ratio of crossover days to total Medicaid days, utilizing information used for the Medicaid percentage adjustment determination described in Section 148.122, effective October 1, 2004, of greater than 40 percent and that did not qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 on October 1, 2004.
- b) The following classes of hospitals are ineligible for Crossover Percentage Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(1)(B).
 - 4) Cancer center hospitals.
- c) **Crossover Percentage Adjustment Payments**
 - 1) Each qualifying hospital's crossover days will be divided by its total Medicaid days to determine the crossover percentage ratio.
 - 2) Each hospital qualifying under subsection (a) of this Section, located in an other urban area as described in subsection (e)(5) of this Section, shall receive payment equal to \$140 multiplied by the hospital's total Medicaid days (including Medicaid/Medicare crossovers).
 - 3) Each hospital qualifying under subsection (a) of this Section located in a large urban area as described in subsection (e)(4) of this Section, with a crossover percentage less than 55 percent, shall receive payment equal to

\$350 multiplied by the hospital's total Medicaid days (including Medicaid/Medicare crossovers).

- 4) Each hospital qualifying under subsection (a) located in a large urban area as described in subsection (e)(4) of this Section, with a crossover percentage ratio equal to or greater than 55 percent, shall receive payment equal to \$1,400 multiplied by the hospital's total Medicaid days (including Medicaid/Medicare crossovers).
- 5) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

- 1) For the crossover percentage adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.
- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

- 1) "Cancer center hospital" means an Illinois hospital that has received the approval of the American College of Surgeons Commission on Cancer as of June 16, 2005 and provides more than 15 percent of the hospital Medicaid days in State fiscal year 2003 for treating patients with cancer. To be counted as cancer days, the Department will identify cancer days with any claim that contains an ICD-9-CM diagnosis code of 140.0 through 208.9 and 230.0 through 234.9 provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department's paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004. To determine if 15 percent of the hospital Medicaid days were for treating cancer patients, the cancer days will be

divided by the total Medicaid days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department's paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004.

- 2) "Crossover percentage adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 3) "Crossover percentage base period" means the information utilized in the Medicaid percentage adjustment determination as described in Section 148.122 for October 1, 2004.
 - 4) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and with an urban hospital as described in Section 148.25(g)(4).
 - 5) "Other urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a city with a population greater than 50,000 or with a total population in excess of 100,000, and with an urban hospital as described in Section 148.25(g)(4).
 - 6) "Total Medicaid days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, including days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's Medicaid percentage adjustment determination as described in Section 148.122 for October 1, 2004.
- f) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.418 Long Term Acute Care Hospital Adjustment Payments

- a) Qualifying Criteria: Long Term Acute Care Hospital Adjustment Payments described in subsection (b) of this Section shall be made to an Illinois long term stay hospital, as defined in 89 Ill. Adm. Code 149.50(c)(4), excluding:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) Long Term Acute Care Hospital Adjustment Payments
 - 1) For a hospital qualifying under subsection (a) of this Section that qualified for a Medicaid Percentage Adjustment Payments under Section 148.122 for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal to the product of \$125 multiplied by Medicaid inpatient days provided during the long term acute care hospital base period.
 - 2) For a hospital qualifying under subsection (a) of this Section that did not qualify for Medicaid Percentage Adjustment Payments under Section 148.122 for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal to the product of \$1,250 multiplied by Medicaid inpatient days of care provided during the long term acute care hospital base period.
 - 3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).
- c) Payment to a Qualifying Hospital
 - 1) For the long term acute care hospital adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the

amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

- 1) “Long term acute care hospital adjustment period” means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 2) “Long term acute care hospital base period” means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.
- 3) “Medicaid inpatient days” means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department’s paid claims data for admissions occurring in the long term care hospital base period that was adjudicated by the Department through June 30, 2004.

e) Payment Limitations: Payments under this Section are not due and payable until:

- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.420 Obstetrical Care Adjustment Payments

- a) Qualifying Criteria. Obstetrical Care Adjustment Payments shall be made to a qualifying Illinois hospital that provided obstetrical care in the obstetrical base period. A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment for the rate year 2006 determination.
- b) The following classes of hospitals are ineligible for Obstetrical Care Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(1)(B).
- c) Obstetrical Care Adjustment Payments
 - 1) A hospital qualifying under subsection (a) of this Section shall receive payments equal to the product of \$550 multiplied by the qualifying hospital's Medicaid obstetrical days provided during the obstetrical care base period.
 - 2) A hospital qualifying under subsection (a) of this Section that qualified for disproportionate share payment adjustments as described in Section 148.120 as of October 1, 2004, with a Medicaid obstetrical percentage greater than ten percent and a Medicaid emergency care percentage greater than 40 percent, shall receive payments equal to the product of \$650 multiplied by the qualifying hospital's Medicaid obstetrical days provided during the obstetrical care base period.
 - 3) A hospital qualifying under subsection (a) of this Section located in the St. Louis metropolitan statistical area, with more than 500 Medicaid obstetrical days, shall receive payments equal to the product of \$1,800 multiplied by the qualifying hospital's Medicaid obstetrical days provided during the obstetrical care base period.
 - 4) A large urban hospital qualifying under subsection (a) of this Section that has a Medicaid obstetrical percentage greater than 25 percent and is in a

county with an eligibility growth percentage rate greater than 60 percent between the years 1998 and 2003 shall receive payments equal to the product of \$600 multiplied by the qualifying hospital's Medicaid obstetrical days provided within the obstetrical care base period.

- 5) A rural hospital as described in Section 148.25(g)(3) qualifying under subsection (a) designated as a Level II perinatal center as of January 1, 2005, with a MIUR greater than 34 percent in State fiscal year 2002 and a Medicaid obstetrical percentage greater than 15 percent, shall receive payment equal to the product of \$400 multiplied by the hospital's Medicaid obstetrical days provided within the obstetrical care base period multiplied by 6.
- 6) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

- 1) For the obstetrical care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.
- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

- 1) "Emergency care percentage" means a fraction, the numerator of which is the total Category 3 ambulatory procedure listing services, excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2003 contained in the Department's data base adjudicated through June 30, 2004, and the denominator of which is the total ambulatory procedure listing services, excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2003

contained in the Department's data base adjudicated through June 30, 2004.

- 2) "Growth percentage" means, for a given hospital, the percentage of change in the growth of Medicaid clients within the county where the hospital is located from 1998 to 2003.
 - 3) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000.
 - 4) "Medicaid obstetrical days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, with a Diagnosis Related Grouping (DRG) of 370 through 375; excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the obstetrical base period the Department adjudicated through June 30, 2004.
 - 5) "Medicaid obstetrical percentage" means the percentage used in the October 1, 2004 Medicaid percentage adjustment determination as described in Section 148.122.
 - 6) "Obstetrical care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 7) "Obstetrical care base period" means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.
- f) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.422 Outpatient Access Payments

- a) Qualifying Criteria: Outpatient Access Payments, as described in subsection (b) of this Section, shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital shall qualify for payment if it was assessed as described in 89 Ill. Adm. Code 140.80 for the rate year 2006 determination, excluding the following hospitals:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) Outpatient Access Payments
 - 1) Outpatient access payments shall be made to a hospital qualifying under subsection (a) of this Section. Payment will equal 2.38 multiplied by the hospital's outpatient ambulatory procedure listing payments for services provided in the outpatient access base period, multiplied by the change in the growth percentage of Medicaid clients within the hospital's county from State fiscal year 1998 to State fiscal year 2003.
 - 2) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).
- c) Payment to a Qualifying Hospital
 - 1) For the outpatient access adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) have been met.

- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- d) Definitions
- 1) “Growth percentage” means, for a given hospital, the percentage of change in the growth of Medicaid clients within the county where the hospital is located from 1998 to 2003.
 - 2) “Outpatient access adjustment period” means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 3) “Outpatient access base period” means the 12-month period beginning on July 1, 2002 and ending June 30, 2003.
 - 4) “Outpatient ambulatory procedure listing payments” means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department’s paid claims data for admissions occurring in the outpatient access base period that were adjudicated by the Department through June 30, 2004.
- e) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.424 Outpatient Utilization Payments

- a) Qualifying Criteria: Outpatient Utilization Payments, as described in subsection (b) of this Section, shall be made to an Illinois hospital, excluding:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) Outpatient Utilization Adjustment Payments
 - 1) A rural hospital, as described in Section 148.25(g)(3) and qualifying under subsection (a) of this Section shall receive an amount equal to 1.7 multiplied by the hospital's outpatient ambulatory procedure listing payments for services provided during the outpatient utilization adjustment base period.
 - 2) An urban hospital, as described in Section 148.25(g)(4) and qualifying under subsection (a) of this Section shall receive an amount equal to 0.45 multiplied by the hospital's outpatient ambulatory procedure listing payments for services provided during the outpatient utilization adjustment base period.
 - 3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).
- c) Payment to a Qualifying Hospital
 - 1) For the outpatient utilization adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) have been met.

- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- d) Definitions
- 1) “Outpatient ambulatory procedure listing payments” means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b)(1), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department’s paid claims data for admissions occurring in the outpatient access base period that were adjudicated by the Department through June 30, 2004.
 - 2) “Outpatient utilization adjustment period” means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 3) “Outpatient utilization base period” means the 12-month period beginning on July 1, 2002, and ending June 30, 2003.
- e) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.426 Outpatient Complexity of Care Adjustment Payments

- a) **Qualifying Criteria:** Outpatient Complexity of Care Adjustment Payments, as described in subsection (b) of this Section, shall be made to Illinois hospitals located in an urban area as described in Section 148.25(g)(4), excluding:
 - 1) County-owned hospitals, as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) **Outpatient Complexity of Care Adjustment Payments**
 - 1) Each hospital qualifying under subsection (a) of this Section will receive a payment equal to the product of 2.55, multiplied by the hospital's emergency care percentage, multiplied by the hospital's ambulatory procedure listing payments.
 - 2) Each children's hospital qualifying under subsection (a) of this Section, with a Medicaid inpatient utilization rate greater than 90 percent used for the October 1, 2004 Medicaid percentage adjustment determination described in Section 148.122, shall have the adjustment, as calculated in subsection (b)(1), multiplied by 2.
 - 3) Each cancer center hospital qualifying under subsection (a) of this Section, shall have the adjustment, as calculated in (b)(1), multiplied by 3.
 - 4) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).
- c) **Payment to a Qualifying Hospital**
 - 1) For the outpatient complexity of care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the

amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) have been met.

- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

- 1) “Cancer center hospital” means an Illinois hospital that has received the approval of the American College of Surgeons Commission on Cancer as of June 16, 2005 and provides more than 15 percent of the hospital Medicaid days in State fiscal year 2003 for treating patients with cancer. To be counted as cancer days, the Department will identify cancer days with any claim that contains an ICD-9-CM diagnosis code of 140.0 through 208.9 and 230.0 through 234.9 provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department’s paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004. To determine if 15 percent of the hospital Medicaid days were for treating cancer patients, the cancer days will be divided by the total Medicaid days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department’s paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004.
- 2) “Emergency care percentage” means a fraction, the numerator of which is the total Group 3 ambulatory procedure listing services as described in Section 148.140(b)(1)(C), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2003 contained in the Department’s data base adjudicated through June 30, 2004, and the denominator of which is the total ambulatory procedure listing services as described in Section 148.140(b)(1), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2003 contained in the Department’s data base adjudicated through June 30, 2004.
- 3) “Outpatient ambulatory procedure listing payments” means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b)(1), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare

crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient complexity of care base period that were adjudicated by the Department through June 30, 2004.

- 4) "Outpatient complexity of care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 5) "Outpatient complexity of care base period" means the 12-month period beginning on July 1, 2002 and ending June 30, 2003.
- e) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.428 Rehabilitation Hospital Adjustment Payments

- a) Qualifying Criteria. Rehabilitation Hospital Adjustment Payments, as described in subsection (c) of this Section, shall be made to a qualifying Illinois freestanding rehabilitation hospital that did not qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 for the 12-month period beginning on October 1, 2004, if not otherwise excluded under subsection (b) of this Section.
- b) The following classes of hospitals are ineligible for Rehabilitation Hospital Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in 89 Ill. Adm. Code 148.25(b)(6).
- c) Rehabilitation Hospital Adjustment Payments for hospitals qualifying under subsection (a) of this Section will receive an amount equal to three multiplied by the hospital's outpatient ambulatory procedure listing payments for Group 6A services provided during the rehabilitation hospital base period.
- d) Payment to a Qualifying Hospital
 - 1) For the rehabilitation hospital adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.
 - 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- e) Definitions

- 1) “Outpatient ambulatory procedure listing payments for Group 6A services” means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b)(1)(F), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department’s paid claims data for admissions occurring in the rehabilitation hospital base period that were adjudicated by the Department through June 30, 2004.
 - 2) "Rehabilitation hospital adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 3) “Rehabilitation hospital base period” means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.
- f) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.430 Perinatal Outpatient Adjustment Payments

- a) **Qualifying Criteria.** Perinatal Outpatient Adjustment Payments shall be made to qualifying Illinois general acute care hospitals that were designated as a perinatal center as of January 1, 2005. A hospital not otherwise excluded under subsection (b) of this Section for the perinatal outpatient adjustment period determination shall qualify for payment if the hospital:
 - 1) Is located in a large urban area;
 - 2) Has a Medicaid obstetrical percentage of at least ten percent used for the October 1, 2004 Medicaid percentage adjustment determination as described in Section 148.122;
 - 3) Has a Medicaid intensive care unit percentage of at least three percent; and
 - 4) Has a ratio of ambulatory procedure listing for total Group 3 services, described in Section 148.140(b)(1)(C), to total ambulatory procedure services, as described in Section 148.140(b)(1), of at least 50 percent.
- b) The following classes of hospitals are ineligible for Perinatal Outpatient Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- c) **Perinatal Outpatient Adjustment Payments**
 - 1) A hospital qualifying under subsection (a) of this Section shall receive payment equal to the product of \$550 multiplied by the hospital's ambulatory procedure listing for emergency Level I services described in Section 148.140(b)(1)(C)(i) provided in the perinatal outpatient base period.

- 2) For a hospital that, as of January 1, 2005, was designated a Level II+ or III perinatal center qualifying under subsection (a) of this Section, the payment calculated in subsection (c)(1) will be multiplied by four.
 - 3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being preformed under this subsection (c).
- d) Payment to a Qualifying Hospital
- 1) For the perinatal outpatient adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.
 - 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- e) Definitions
- 1) “Large urban area” means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and with an urban hospital as described in Section 148.25(g)(4).
 - 2) “Medicaid intensive care unit percentage” means a fraction, the numerator of which is the number of hospital inpatient days during which Medicaid recipients received intensive care services from the hospital, as determined from the hospital’s fiscal year 2002 Medicaid cost report on file with the Department as of July 1, 2004, and the denominator of which is the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as contained in the hospital’s cost

report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

- 3) "Outpatient ambulatory procedure listing emergency Level I services" means, for a given hospital, the sum of services for ambulatory procedure listing services as described in Section 148.140(b)(1)(C)(i), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the perinatal outpatient base period that were adjudicated by the Department through June 30, 2004.
 - 4) "Perinatal outpatient adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 5) "Perinatal outpatient base period" means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.
- f) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.432 Supplemental Psychiatric Adjustment Payments

- a) **Qualifying Criteria:** Supplemental Psychiatric Adjustment Payments shall be made to a qualifying hospital as defined in this subsection (a). An Illinois hospital shall qualify for payment if it did not qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 for the 12-month period beginning October 1, 2004, but is eligible for psychiatric adjustment payments as described in Section 148.105 for fiscal year 2005, excluding:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) Supplemental Psychiatric Adjustment Payments will be made to qualifying hospitals and will equal the product of the hospital's fiscal year 2005 Psychiatric Adjustment Payments, as described in Section 148.105, multiplied by 0.7.
- c) **Payment to a Qualifying Hospital**
 - 1) For the supplemental psychiatric adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.
 - 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- d) "Supplemental base rate adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, means the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- e) **Payment Limitations:** Payments under this Section are not due and payable until:

- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
- 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
- 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

Section 148.434 Outpatient Community Access Adjustment Payments

- a) Qualifying Criteria: Outpatient Community Access Adjustment Payments, as described in subsection (b) of this Section, shall be made to an Illinois general acute care hospital as described in Section 148.270(c)(1) that was designated as a perinatal center as of January 1, 2005, that had a Medicaid obstetrical percentage used for the October 1, 2004 Medicaid percentage adjustment determination described in Section 148.122 of at least 12.5 percent, that had a ratio of crossover days to total Medicaid days greater than or equal to 25 percent utilizing information used for the Medicaid Percentage Adjustment Payment described in Section 148.122, and that qualified for Medicaid Percentage Adjustment Payments as described in Section 148.122 on October 1, 2004, excluding:
 - 1) County-owned hospitals as described in Section 148.25(b)(1)(A).
 - 2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- b) Outpatient Community Access Adjustment Payments
 - 1) Hospitals qualifying under subsection (a) of this Section shall receive an amount equal to \$100 multiplied by the hospital's outpatient ambulatory procedure listing services in the outpatient community access base period.
 - 2) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).
- c) Payment to a Qualifying Hospital
 - 1) For the outpatient community access adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

- 2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.
- d) Definitions
- 1) “Outpatient ambulatory procedure listing services” means, for a given hospital, the sum of services for ambulatory procedure listing services as described in Section 148.140(b)(1), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department’s paid claims data for admissions occurring in the outpatient community access base period that were adjudicated by the Department through June 30, 2004.
 - 2) “Outpatient community access adjustment period” means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12 month period beginning July 1 of the year and ending June 30 of the following year.
 - 3) “Outpatient community access base period” means the 12-month period beginning on July 1, 2002 and ending June 30, 2003.
- e) Payment Limitations: Payments under this Section are not due and payable until:
- 1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;
 - 2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and
 - 3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 30 Ill. Reg. 383, effective December 28, 2005)

SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

Section 148.500

Definitions

"Act" means the Sexual Assault Survivors Emergency Treatment Act [410 ILCS 70].

"Alleged Sexual Assault Survivor" means a person who seeks hospital emergency services in relation to injuries or trauma resulting from an alleged act of forced sexual penetration or sexual conduct, as defined in Section 12-12 of the Criminal Code of 1961 [720 ILCS 5/12-12], including acts prohibited under Sections 12-13 through 12-16 of the Code [720 ILCS 5/12-13 through 12-16] and Sections 1a and 2 of the Act [410 ILCS 70/1a and 2].

"Ambulance Provider" means an ambulance service providing transportation for alleged sexual assault survivors.

"Department" means the Illinois Department of Public Aid.

"Evidence Collection Kit" means a prepackaged set of materials and forms that has been approved by the Illinois State Police to be used for the collection of evidence relating to sexual assault. The standardized evidence collection kit for all parts of the State shall be the Illinois State Police Sexual Assault Evidence Collection Kit (Section 6.4 of the Act).

"Hospital" means a facility located in Illinois licensed as a hospital by the Department of Public Health pursuant to the Hospital Licensing Act [210 ILCS 85] or that meets both the definition of a hospital and the licensure exemption provisions of the Hospital Licensing Act.

"Hospital Emergency Services" means health care delivered to alleged sexual assault survivors within or under the care and supervision of personnel working in a designated emergency department or emergency room of a hospital.

"Medical Assistance Program" means the Medicaid Program authorized under Title XIX of the Social Security Act and Section 5 of the Public Aid Code [305 ILCS 5/5] and the State Children's Health Insurance Program (SCHIP), authorized under Title XXI of the Social Security Act and the Children's Health Insurance Program Act [215 ILCS 106].

"Transfer Facility" means a hospital that provides only transfer services to alleged sexual assault survivors, pursuant to 77 Ill. Adm. Code 545.

"Treatment Facility" means a hospital that renders emergency treatment to alleged sexual assault survivors, pursuant to 77 Ill. Adm. Code 545.

(Source: Added at 26 Ill. Reg. 4825, effective March 15, 2002)

Section 148.510 Reimbursement

When a hospital or ambulance provider furnishes emergency services to any alleged sexual assault survivor who is neither eligible to receive those services under the Department's Medical Assistance Program nor covered for those services by a policy of insurance, the hospital and ambulance provider shall furnish such services without charge to that person, and shall be entitled to be reimbursed for its billed charges in providing such services, under the following conditions:

- a) An Illinois hospital shall be eligible for reimbursement only after receiving Department of Public Health approval for participation as a Sexual Assault Treatment Facility or as a Sexual Assault Transfer Facility.
- b) Charges for outpatient emergency care, physician, and ambulance transportation, and other related charges shall be reimbursed only through the hospital outpatient billing department.
 - 1) Physicians, ambulance providers, and other miscellaneous medical providers rendering services in the hospital emergency department shall not be directly reimbursed by the Department of Public Aid.
 - 2) Charges for inpatient care shall not be reimbursed.
 - 3) Charges must be directly related to emergency care rendered for examinations, injuries, or trauma resulting from an alleged sexual assault and/or the completion of sexual assault evidence collection through the use and application of the State Police Evidence Collection Kit.
 - 4) Emergency room services must have been provided within the hospital emergency department (room) under the direction of an attending emergency room physician at the facility who supervised or provided the hospital emergency care of the alleged sexual assault survivor, or during the ambulance transport of the alleged sexual assault survivor.
 - 5) Charges may include, but are not limited to, physician, laboratory, x-ray, pharmacy and ambulance services, including charges for no more than two follow-up visits to the emergency department that are related to the alleged sexual assault and occur within six weeks after the initial visit.
 - 6) The billed charges for services provided to alleged sexual assault survivors shall be no greater than the provider's customary charges to the general public for those types of services. Physician fees shall be no greater than those considered usual and customary in the community.
 - 7) Claims must be received by the Department within 12 months from the date of service to be eligible for payment.
- c) The hospital shall maintain sufficient records to document its charges for services to each alleged sexual assault survivor. The records shall be available for the Department's review upon its request and shall contain at least the following:

- 1) Alleged sexual assault survivor's name, address, date of birth, Social Security Number, marital status, sex, employer and name of parent or guardian (if minor patient);
 - 2) Date of service;
 - 3) Hospital patient number and name of attending physician;
 - 4) List of services provided;
 - 5) Charges for each service;
 - 6) Any documentation concerning the alleged sexual assault survivor's insurance coverage; and
 - 7) A report outlining each service provided and paid for by the Department and the services available to alleged sexual assault survivors.
- d) The hospital outpatient billing department shall submit the following documentation in order to be considered for reimbursement:
- 1) The Illinois Department of Public Aid Sexual Assault Survivor Program Outpatient Hospital Billing Form, completed in its entirety for the initial visit and follow-up visits;
 - 2) When applicable, the Billing Form with documentation of any insurance payment that has been received, or a copy of the denial from the insurance carrier;
 - 3) A legible copy of the emergency room admission form with physician's notes and orders and nurse's notes; and
 - 4) Itemized statement of all charges from each provider.
- e) Under no circumstances shall an alleged sexual assault survivor be billed for outpatient hospital care, emergency room care or transportation services when the services are directly related to the sexual assault.
- f) A request for reimbursement that is rejected by the Department shall be returned to the requestor and accompanied by an explanation that specifies the basis for rejection. Corrected or amended requests may be resubmitted to the Department within 12 months from the date of service.

(Source: Added at 26 Ill. Reg. 4825, effective March 15, 2002)

SUBPART D: STATE CHRONIC RENAL DISEASE PROGRAM

Section 148.600 Definitions

“Committee” means the Renal Disease Advisory Committee. The Committee, which is appointed by the Department’s Director, consults with the Department in the administration of the Renal Disease Treatment Act [410 ILCS 430]. The Committee is composed of 15 persons representing entities involved in or interested in kidney diseases, to include hospitals and medical schools, physicians, voluntary agencies and the general public. The Committee meets at least once each year, as specified in the Act.

“Department” means the Illinois Department of Public Aid.

“Dialysis Facility” means a facility that provides dialysis treatments such as in-facility and home dialysis and is certified by the federal Centers for Medicare & Medicaid Services as a Medicare-approved dialysis facility.

“Dialysis Treatment” means the filtering of blood in order to remove liquid and unwanted material so that fluid, electrolyte and acid-base balance in the blood can be maintained.

“End Stage Renal Disease” means the level of renal impairment that is irreversible and permanent, results in the kidneys losing their ability to filter blood and excrete urine, and requires a regular course of dialysis or kidney transplantation to maintain life.

“Patient” means an eligible person whose kidneys are non-functioning or absent and who requires dialysis treatment to maintain life.

“Program” means the Illinois Department of Public Aid’s State Chronic Renal Disease Program.

(Source: Added at 26 Ill. Reg. 4825, effective March 15, 2002)

Section 148.610 Scope of the Program

a) General Description

The Illinois Department of Public Aid's State Chronic Renal Disease Program assists patients with End Stage Renal Disease who have not qualified for benefits under Medical Assistance or KidCare. The Program assists eligible patients suffering from chronic renal diseases who require lifesaving care and treatment for such renal diseases, but who are unable to pay for the necessary services on a continuing basis. The Program is supplementary to all other resources, including Medicare, private insurance and private income. Services under the State Chronic renal Disease Program are not available as emergency medical services to ineligible non-citizens.

b) Role of the Renal Disease Advisory Committee

- 1) The Committee shall act in an advisory capacity to the Department in the development of standards for determining eligibility for care and treatment. Such standards shall provide that Program candidates are evaluated in properly staffed and equipped facilities.
- 2) The Committee shall make recommendations to the Department on financial assistance for patients, including reasonable charges and fees for:
 - A) Treatment in a dialysis facility;
 - B) Hospital treatment for dialysis and transplant surgery;
 - C) Treatment in a limited care facility;
 - D) Home dialysis training; and
 - E) Home dialysis.

(Source: Added at 25 Ill. Reg. 4825, effective March 15, 2002)

Section 148.620 Assistance Level and Reimbursement

- a) Only approved dialysis facilities that are enrolled with the Department shall be reimbursed for dialysis treatments received by eligible patients.
- b) The Department shall reimburse dialysis facilities for a portion of the costs of dialysis treatments provided to eligible patients. The Department will determine annually the rate of reimbursement to be used for the fiscal year, based on Medicare's Composite Payment Rates.
- c) Assistance for chronic outpatient dialysis patients who are Medicare eligible, but who also qualify for the Program for both in-facility dialysis and home dialysis, will not exceed 15 percent of the Medicare rate.
- d) New patients who qualify for chronic outpatient dialysis assistance during the waiting period for Medicare eligibility (60 to 90 days from the date of first dialysis) will be assisted at a maximum of 95 percent or less of the rate established under subsection (b) of this Section.
- e) Patients who will never be eligible or qualify for Medicare will be assisted at a maximum of 95 percent or a minimum of 80 percent of the rate established under subsection (b).

(Source: Added at 26 Ill. Reg. 4825, effective March 15, 2002)

Section 148.630 Criteria and Information Required to Establish Eligibility

- a) An eligible person shall:
 - 1) Be a resident of the State of Illinois as provided in 305 ILCS 5/2-10; and
 - 2) Meet requirements of citizenship as provided in 305 ILCS 5/1-11.
- b) The following information shall be verified by the dialysis facility and maintained in the patient's record:
 - 1) Citizenship or immigration status;
 - 2) Address; and
 - 3) Social Security Number.
- c) Eligibility of patients shall be determined by the Department based on the information required in this Section. To maintain eligibility for participation in the Program, a patient shall meet the following criteria on an ongoing basis:
 - 1) A physician's diagnosis of End Stage Renal Disease for the patient must be on file at the dialysis facility;
 - 2) The designated Department of Human Services office has determined the patient is not eligible for medical assistance; and
 - 3) The patient shall provide documentation to the dialysis facility of his or her ineligibility for non-spenddown Medicaid or QMB (Qualified Medicare Beneficiary) status.
- d) Participation Fees
 - 1) Participants in the Program shall be responsible for paying a monthly participation fee to the dialysis facility from which they receive dialysis treatment. The amount of the Department's payment, as determined under Section 148.620, shall be reduced by the amount of the participation fee. The fee shall be determined by the Department based on income and information contained in the Bureau of Labor Statistics (BLS) standards, as described in Section 148.Table B, and calculated pursuant to the Direct Care Program Renal Participation Worksheet (Section 148.Table A).
 - 2) The following shall be obtained and verified by the dialysis facility and submitted with the patient's application to the Department for determination of the amount of a patient's participation fee.
 - A) Pay Stubs for the 90 days preceding the date of signature on the application if not employed for the past year; or
 - B) Previous year's federal and State Income Tax Returns if employed during the previous year.
 - 3) The following are allowed as deductions from income:
 - A) Federal, State and local taxes;
 - B) Special care for children;
 - C) Support (child, relative or alimony);
 - D) Retirement or Social Security benefits;
 - E) Employment expenses (union dues, special tools and clothing);

- F) Transportation to and from the site of dialysis; and
 - G) Medical expenses, both paid and outstanding.
- 4) If a substantial change in the financial status of any patient occurs after the patient has been found eligible for the Program, the patient shall report the change to the dialysis center. Based on the extent of the change, a new participation fee may be determined and imposed by the Department.
- e) The following shall be verified by the dialysis facility and submitted with the patient's application to the Department for determination of nonfinancial eligibility by the Department:
 - 1) Third Party Liability
 - A) Proof of insurance coverage; and
 - B) Proof of Medicare coverage.
 - 2) Consent form required under subsection (f) of this Section, signed by the patient or his or her representative.
- f) The applicant or the applicant's parent or guardian must sign a consent form authorizing the release of all medical and financial records to the Department and to an approved chronic renal disease treatment facility.

(Source: Added at 26 Ill. Reg. 4825, effective March 15, 2002)

Section 148.640 Covered Services

Assistance may be provided for eligible patients for costs associated with:

- a) Prescribed medication related to chronic renal disease treatment;
- b) Transportation to and from the site of dialysis or the site of out-patient post transplantation care when such needs are defined as emergency situations by the physician and social worker in the approved facility; and
- c) Laboratory tests, not otherwise covered, that are related to the patient's status after a transplantation procedure. The laboratory tests are covered for three years after the date of transplantation.

(Source: Added at 26 Ill. Reg. 4825, effective March 15, 2002)

Section 148.TABLE A Renal Participation Fee Worksheet

Date _____
Initialed _____
Patient Identification Number _____

PATIENT'S NAME _____
Last First Middle Initial

In questions 1 through 4 below, please circle one number or group of numbers:

1. NUMBER OF PERSONS IN FAMILY 1 2 3 4 5 6 or more
2. NUMBER OF CHILDREN 1 2 3 4 5 or more
3. AGE OF OLDEST CHILD IN YEARS 0-5 6-15 16-17 18 and over
4. AGE OF HEAD OF HOUSEHOLD Under 35 35-54 55-64 65 and over

BUREAU OF LABOR STATISTICS (BLS) EQUIVALENCE FACTOR = _____
(see Table B)

A. LOCATION
(See Table C, List of Metropolitan Counties by SMSA Definition)

BLS METRO = \$12,815
BLS NON-METRO = \$11,604

B. STANDARD BUDGET

BLS EQUIVALENCE FACTOR		BLS STANDARD BUDGET		FAMILY STANDARD BUDGET
\$ _____	X	\$ _____ (metro or non-metro)	=	\$ _____

C. PARTICIPATION DETERMINATION

ADJUSTED GROSS INCOME		FAMILY STANDARD BUDGET		
\$ _____	-	\$ _____	=	\$ _____ X .333 = \$ _____

D. ADJUSTED GROSS INCOME

\$ _____ X .125 = \$ _____

LESSER OF C or D = \$ _____

E. ADJUSTED GROSS INCOME = \$ _____

FAMILY STANDARD BUDGET = \$ _____
(B. above)

F. FEDERAL INCOME TAX STATE INCOME TAX TOTAL TAX

\$ _____ + \$ _____ = \$ _____

TOTAL TAX

BLS STANDARD TAX

\$ _____ \$ _____ = \$ _____
(metro \$1,435)
(non-metro \$1,260)

G. SPECIAL CARE FOR CHILDREN \$ _____

H. SCHOOL TUITION \$ _____

I. FAMILY SUPPORT PAID \$ _____

J. OTHER PAYMENTS

1. Transportation to and from dialysis \$ _____

2. Employment Expense (dues, uniforms, small tools) \$ _____

SOCIAL SECURITY PAID

BLS STANDARDS

\$ _____ - \$ _____ = \$ _____
(metro \$702)
(non-metro \$676)

K. MEDICAL EXPENSES

BLS STANDARD

MEDICAL EXPENSES
ALLOWED

\$ _____ = \$ _____
(includes medical
insurance premiums) (metro \$876)
(non-metro \$671)

MEDICAL EXPENSES
ALLOWED

TOTAL EXPENSES

INCOME IN EXCESS

\$ _____ - \$ _____ = \$ _____
(E through K totaled, less
adjusted gross income)

L. INCOME IN EXCESS

\$ _____ X .333 = \$ _____

M. ENTER SMALLEST AMOUNT OF C or D or L

\$ _____

(Source: Added at 26 Ill. Reg. 4825, effective March 15, 2002)

Section 148.TABLE B Bureau of Labor Statistics Equivalence

Revised Scale of Equivalent Income for Urban Families of Different Size, Age and Composition
(four person family - husband, age 35-54, wife, 2 children, oldest 6-15 = 100 percent)

AGE OF HEAD OF HOUSEHOLD

SIZE AND TYPE OF FAMILY	Under 35	35-54	55-64	65 and Over
-------------------------	----------	-------	-------	-------------

Percentages to be Applied to the Total Cost of a Budget
(excluding State and local income taxes and disability payments)

One person	37%	38%	33%	28%
------------	-----	-----	-----	-----

Two persons:

Husband and wife	50%	61%	60%	51%
------------------	-----	-----	-----	-----

One parent and child	40%	59%	62%	58%
----------------------	-----	-----	-----	-----

Three persons:

Husband, wife, child under 6	62%	69%	70%	68%
------------------------------	-----	-----	-----	-----

Husband, wife, child 6-15	62%	83%	89%	81%
---------------------------	-----	-----	-----	-----

Husband, wife, child 16-17	83%	92%	89%	78%
----------------------------	-----	-----	-----	-----

Husband, wife, child 18 or over	82%	83%	86%	77%
---------------------------------	-----	-----	-----	-----

One parent, 2 children	68%	77%	84%	75%
------------------------	-----	-----	-----	-----

Four persons:

Husband, wife, 2 children, oldest under 6	71%	79%	80%	80%
--	-----	-----	-----	-----

Husband, wife, 2 children, oldest 6-15	76%	100%	105%	95%
---	-----	------	------	-----

Husband, wife, 2 children, oldest 16-17	113%	114%	126%	110%
--	------	------	------	------

Husband, wife, 2 children, oldest 18 or over	96%	96%	110%	89%
---	-----	-----	------	-----

One parent, 3 children	88%	97%	97%	87%
------------------------	-----	-----	-----	-----

Five persons:

Husband, wife, 3 children, oldest under 6	85%	95%	97%	0%
--	-----	-----	-----	----

Husband, wife, 3 children, oldest 6-15	94%	115%	119%	0%
---	-----	------	------	----

Husband, wife, 3 children, oldest 16-17	128%	128%	138%	0%
Husband, wife, 3 children, oldest 18 or over	119%	118%	124%	0%
One parent, 4 children	108%	117%	118%	0%

Six persons or more:

Husband, wife, 4 children or more, oldest under 6	98%	114%	115%	0%
Husband, wife, 4 children or more, oldest 6-15	107%	130%	139%	0%
Husband, wife, 4 children or more, oldest 16-17	146%	145%	147%	0%
Husband, wife, 4 children or more, oldest 18 or over	149%	149%	150%	0%
One parent, 5 children or more	124%	137%	138%	0%

The scale values shown here are percentages to be applied to the total cost of a budget (excluding State and local income taxes, and disability payments) for the base family (4 persons-husband, age 35-54, wife, 2 children, oldest child 6-15 years) to estimate the total income required to provide the same level of living for urban families of different size, age, and composition. In addition to the cost of goods and services for family consumption, the total budget costs include gifts and contributions, life insurance, occupational expenses, employee contribution for social security, and federal income taxes. Estimates of personal taxes paid to State and local governments and of payments for disability insurance may be added in those urban areas where applicable.

(Source: Added at 26 Ill. Reg. 4825, effective March 15, 2002)

Section 148.TABLE C List of Metropolitan Counties by SMSA Definition

“SMSA” means State Metropolitan Statistical Areas.

Boone	Champaign	Clinton	Cook	DuPage
Henry	Kane	Lake	Macon	Madison
McHenry	McLean	Menard	Monroe	Peoria
Rock Island	Sangamon	St. Clair	Tazewell	Will
Winnebago	Woodford			

(Source: Added at 26 Ill. Reg. 4825, effective March 15, 2002)